Tampa HSC HIM Shared Services Center

Tampa HCA Shared Service Center – HSC Release of Information
6451 126th Avenue North, Largo, FL 33773
Phone (866) 463-7272 Email: HSCT.MRRequest@Parallon.com

Stat/Continuity of Care Requests Only, Fax to 1-855-446-6008

Section A: This section must be completed for all Authorizations

Patient Name:	**Date of Birth:**	**Patient's Phone:**	**Last 4 digit SSN: (optional)**
Recipient's Name:			
Address 1:	**Address 2:**	**Recipient's Phone:**	
City:	**State:**	**Zip:**	

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.,* USB drive, CD/DVD)**
☐ **Encrypted Email** ☐ **Unencrypted Email** ☐ **Provider Fax Number**_____

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.,* paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.,* virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**

Purpose of disclosure:

Hospital to release records from:

☐ Aventura Hospital and Medical Center	☐ Mercy Hospital	☐ Sister Emmanuel
☐ Highlands Regional Medical Center	☐ Northwest Medical Center	☐ University Hospital and Medical Center
☐ Kendall Regional Medical Center	☐ Plantation General Hospital	☐ Westside Regional Medical Center

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ Abstract (most common)		☐ Operative information		☐ Labor/delivery summary	
☐ Entire medical record		☐ Cath lab		☐ OB nursing assess	
☐ Admission form		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Dictation reports		☐ Rhythm strips		☐ Itemized bill:	
☐ Physician orders		☐ Nursing information		☐ UB-04:	
☐ Intake/outtake		☐ Transfer forms		☐ Other:	
☐ Clinical test/radiology result		☐ ER information		☐ Other:	
☐ Medication sheets					

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I can get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ No
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial payment in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:
May the recipient of the PHI further exchange the information for financial payment? ☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

ID verified by: _____ (Initials)

Patient Label

Directions for Completing the Authorization to Release Information

****Note: Release of information will occur after hospital discharge**

Section A:

1. Provide the patient's name, date of birth, phone number, and last 4 digits of SSN (this is optional).
2. Provide the name of the recipient (receiver) of the information. The recipient is whoever is going to receive the records. The recipient of the information may be someone other than the patient. It may be the patient's spouse, parent, power of attorney, another healthcare provider, etc. If the recipient's name is the same as the patient, just write "SELF"
3. If the recipient is the patient, provide the address of the patient. If the recipient is different than the patient, provide the address and phone number of the recipient.
4. Next check the method of delivery: paper copy, electronic copy (CD, DVD, etc) or email. If you want the information faxed to your provider, indicate the fax number. If by email, select whether you want the email encrypted or not encrypted. Provide the email address, if you selected email. When requesting medical records to be sent unencrypted via email, your health information is not protected from unauthorized access.
5. Indicate when this form expires. Put a date or an event (event example: the end of my outpatient therapy), but not both.
6. Provide the reason for disclosure, examples are: further treatment, insurance purposes, for attorney, personal use, etc.
7. Indicate from which hospital you need records.
8. Were you seen by a psychiatrist/psychologist while at the hospital and do you want notes by them? If YES, select YES and you have to fill out two authorization forms, one for the behavioral health reports and one for the other types of reports. If NO, select NO and continue.
9. At **DESCRIPTION** indicate what information you are requesting. Most common is the abstract, which contains the discharge summary, history and physical, ER report, consults and operative reports from the physicians, along with test results such as labs, radiology, and pathology. Otherwise, indicate the specific information you need. Please indicate the dates of service.
10. Initial that you acknowledge and consent that the information requested may contain the special types of information listed.
11. There may be a copy fee for the information you requested. Most requests will be sent to our copy service at Tampa Shared Service Center. Their contact information is on the top of the other side of this form.

Section B:

1. Are you using the information you requested for marketing purposes or selling the information, if not, answer NO and skip the next two questions and go to Section C. If YES, answer YES and continue with the next two questions.
2. If you are going to receive money in exchange for this information, answer YES. Otherwise answer NO.
3. If you give permission to the recipient (receiver) to exchange the information for money, answer YES. Otherwise answer NO.

Section C:

1. The patient must sign and date the form. OR
2. The patient's LEGAL representative, example: power of attorney, legal guardian, healthcare surrogate, must sign and date the form. (A spouse is not a LEGAL representative unless they have LEGAL power of attorney or healthcare surrogacy paperwork.)
3. A copy of the LEGAL paperwork must be with this request.

Please send a copy of the patient's ID or the legal paperwork mentioned above, along with this request, to Tampa Shared Service Center. Their contact information is on the other side of this form.