FIU HEALTH
FACULTY GROUP PRACTICE

Medical Information Request Form
Authorization for Use or Disclosure of Protected Health Information

Patient name: _____
Address: _____
Telephone: _____ DOB: _____ FGP Patient ID number: _____

1. By signing this form, I give my permission to:	2. to release to, including in print, oral or electronic format:

3. Patient protected health information created or used by FGP, including (check the applicable information):

□ Office visit notes;
□ Procedure notes;
□ Laboratory Test results;
□ Immunization record
□ Records of drugs prescribed, dispensed, or administered;
□ Reports of consultations
□ Imaging studies (X-ray, Ultrasound)
□ EKG
□ Other (specify report type or information you want released): _____

4. What date/s of service does the request cover: (from): _____ (to): _____

5. Copy media: □ print copies □ electronic copies (on patient supplied disk or portable drive)

6. Purpose of request: □ Treatment/continued care □ Other reason

This authorization is for release of patient information contained in the patient record or designated record set, including diagnosis, treatment, and/or examination related to physical health, mental health, substance and/or alcohol abuse, HIV/AIDS, and sexually transmissible diseases. By signing this authorization, I am giving permission for the uses and disclosures of patient information described above.

I understand that I have a right to inspect and to obtain a copy of any information disclosed. I understand that state law or Federal law, including 42 C.F.R. part 2, may prohibit the re-disclosure of the information disclosed to the persons/entities listed above without my further written authorization, but that FIU cannot guarantee that the recipient(s) of the information will not re-disclose this information contrary to such prohibition. Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

I understand that this authorization will remain in effect until the request has been fulfilled or on a date specified by the requester (fill in date, if any :_____), or until I revoke it in writing.

I understand that I have the right to revoke this authorization but only to the extent that FIU has not already relied on this authorization. The revocation of this notice is effective except as indicated in the FIU Notice of Privacy Practices. I may revoke this authorization by providing a written statement to the Practice Manager at the FIU site where I received my care. I understand that FIU cannot condition my treatment or payment for health care on this Authorization, unless the treatment is research related or the care was provided solely to provide information for a third party. There is no fee for records copied for purposes of continuing medical treatment by a health care provider. For records provided for other purposes, however, I understand that I may be charged a fee not to exceed state or federal allowable amount.

Printed name/Legal Personal Representative: _____

Signature of patient /Legal Personal Representative:_____ **Date** _____

If personal representative, what is the relationship between the legal representative and the Patient:
□ Parent of a minor □ Guardian □ Other personal representative (explain: _____)