**Record Request: Authorization to Use and Disclose Protected Health Information ("PHI") Maintained by UF Health***

**For purposes of this agreement, UF Health describes a collaboration of the University of Florida Board of Trustees for the benefit of the University of Florida College of Medicine, Shands Jacksonville Medical Center, Inc., Shands Teaching Hospital and Clinics, Inc., and Shands Recovery, LLC. Collectively, these entities are referred to as UF Health in this form.*

| **Patient Name** | **Date of Birth** | **Medical Record #** | **Verification of Identity** |
|---|---|---|---|
| | | | ○ Driver's License/State ID |
| **Patient's Address** | **City** | **State** **Zip** | ○ Personally known |
| | | | ○ Other |
| **Phone #** | **Last 4 digits of SSN (Optional)** | ○ Check if patient is an employee of UF Health | |

**Complete the section below only if the person requesting records is not the patient:**

| **Name of Representative** | **Relationship to Patient** | **Legal Authority** |
|---|---|---|
| Representative's Address & Phone Number | **Verification of Identity** | **Verification of Authority** |

**By signing this form, I authorize the release of PHI (i.e., medical records) as follows:**

| **FROM** the doctor, office, facility or other health care provider checked or written below: | **TO** the facility/ person below: |
|---|---|
| | ☐ Check here if same as patient ☐ Check here for records **pick-up** only |
| Clinic or Department Name | Clinic, Person, or Organization |
| Address | Address |
| Phone: Attn: | Phone: Attn: |

| **The following PHI may be released** *(describe in detail or use the check boxes below):* | | | **I further authorize the release of the following information which may be included in the PHI:** |
|---|---|---|---|
| ☐ History & Physical | ☐ Operative Reports | ☐ Discharge Summary | ☐ Behavioral Health treatment |
| ☐ Problem List | ☐ Medication List | ☐ Treatment Notes | ☐ Alcohol or Substance Use Disorder |
| ☐ Emergency Room Record | ☐ Radiology Reports / Images | ☐ Lab/Pathology Reports | ☐ STD/HIV/AIDS treatment or test(s) |
| ☐ Other _____ | | | ☐ Genetic Testing |

| **Is this needed for a doctor's appointment?** | Write date below | **Are there specific dates needed?** | Write dates below |
|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| **Purpose of this request:** | ○ Treatment/Continued Care | ○ Payment/Billing | ○ Legal | ○ Personal Use | ○ Other |
| **Format of records?** | ○ Paper | ○ DVD / CD | ○ Thumb/Flash Drive | ○ My UFHealth Patient Portal | |
| | ○ Provided in electronic format to my e-mail account at: _____ You will receive an e-mail from our vendor (i.e. Iron Mountain) and that e-mail will instruct you how to retrieve your records. | | | | |

This authorization allows UF Health to use and disclose (release) certain PHI, which includes medical records, as I have directed.
I understand that:

- The PHI may include information about mental health, substance and/or alcohol abuse, HIV/AIDS, and STDs.
- I understand that substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Records, 42 C.F.R. Part 2, and HIPAA, 45 C.F.R. parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by these regulations.
- This authorization may be used to share the same type of PHI indicated above which may be created in the future, until the expiration date.
- This authorization will remain in effect for **one (1) year** or until I revoke it in writing (i.e., tell UF Health to cancel it).
- I have the right to revoke this authorization at any time, but only to the extent that UF Health and the Part 2 program (if applicable) has not already relied on this authorization.
- I understand that I must revoke this authorization by writing to the Health Information Management Department at the organization named above and that the revocation will not apply to action already taken as a result of this authorization.
- I may refuse to sign this authorization and doing so will not affect my treatment, payment, enrollment, or eligibility for benefits or the quality of care that I will receive.
- I understand that PHI released per this authorization may no longer be protected by state law or the federal health privacy law and could be re-disclosed by the person or entity that receives it.
- I am aware that I may be charged a fee for this request as allowed by law, which may include up to $1.00 per page (plus applicable tax and handling) for Paper Records and fees associated with labor, supplies (i.e. cost of a computer disk), and postage for Electronic Records. Fees are waived when PHI is released to a health care provider for treatment purposes.

**Signature of Patient / Patient Representative** _____ **Date** _____