**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**
Patient's Address	**City**	**State** / **Zip**	○ Driver's License/State ID ○ 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:

☐ **University of Florida** person or organization:

_____
Clinic, person, or organization

_____
Address

_____
Phone: Attn:

☐ **Shands Jacksonville Medical Center, Inc.,**
d/b/a UF Health Jacksonville 655 W 8th Street, Jacksonville, FL 32209
Phone: 904-244-2596 **Fax:** 904-244-3165

- ☐ **Elizabeth G. Means Center** 1155 E 21st Street, Jacksonville FL 32206
- ☐ **Brentwood Primary Care Center** 3465 Village Center Drive, Jacksonville, FL 32206
- ☐ **Emerson Bone & Joint** 4555 Emerson St., Bldg 1, Suite 100 Jacksonville, FL 32207
- ☐ **UF Health North** 15255 Max Leggett Parkway, Jacksonville, FL 32218

To the facility / person below:

Clinic, person, or organization | Address and Fax Number | ○ Check here if same as patient | ○ Check here for records **pick-up** only

Attn:

The following PHI may be released *(describe in detail or use the check boxes below):*

☐ History & Physical ☐ Operative Reports ☐ Discharge Summary
☐ Problem List ☐ Medication List ☐ Treatment Notes
☐ Emergency Room Record ☐ Radiology Reports / Films ☐ Lab/Pathology Reports
☐ Other _____

I further authorize the release of the following information which may be included in the PHI:

☐ Mental Health/Psychiatric treatment
☐ Alcohol or Substance Abuse treatment
☐ STD/HIV/AIDS treatment or test(s)
☐ Genetic Testing

Is this needed for a doctor's appointment? Write date below

Are there specific dates needed? Write dates below

Purpose:	○ Treatment/Continued Care ○ Payment/Billing ○ Personal Use ○ Other
Format of records?	○ Through a web portal, with notice provided to my e-mail account at: To request records in electronic PDF form, please check the box above and provide a valid and clear e-mail address. You will receive an e-mail from Iron Mountain (IOD) and that e-mail will tell you how to get the records. ○ Paper ○ DVD / CD

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.
- 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, if I do so in 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** _____

Authorization to Use and Disclose Protected Health Information*

UFHealth JACKSONVILLE

Approved: 01/2015
Revised: 02/16/15