Request for Access and Authorization for Use and/or Disclosure of Protected Health Information

FRi - Diagnostic Imaging
Florida Hospital Connected Care

Questions in red are required.

I understand that the protected health information specified below may include mental health, substance abuse (e.g., drugs, alcohol), HIV/AIDS status information, diagnostic and treatment records.

I have read and understand the following statements:

1. I may revoke this authorization at any time by notifying Florida Radiology Imaging in writing.
2. I understand that my revocation does not affect any disclosure made prior to the revocation being received and processed.
3. I understand the information disclosed may be subject to redisclosure and no longer be protected by federal or state privacy laws.
4. I understand that I am signing this form voluntarily and I am signing this under my own free will. Florida Radiology Imaging will not condition my treatment, payment enrollment in health plans or my eligibility for benefits by signing this form.
5. I understand that I will receive a signed copy of this form.
6. I further agree to pay charges to provide the information requested per Florida Statute and Administrative Rule.
7. I understand that unless otherwise revoked, this authorization will expire upon the following date, event or condition: _____.
   If no expiration date, event or condition is noted this authorization will expire one year from the date signed.

☐ I am the patient and I understand and agree to the provisions of this form/authorization.
☐ I understand and agree to the provisions of this form on behalf of the individual indicated below to the patient. I have signed my name individually as the representative of the patient and have attached a copy of the court order designating me as the guardian or the patient, or documentation designating me as the Legally Authorized Person (LAP) for the patient.

Patient's Legal Name: _____ MRN: _____

Address: _____ Last 4 of SSN: _____

Date of Birth: _____ Patient Phone Number: _____

I authorize Florida Radiology Imaging to receive from or sent to:

Persons/organizations providing the information: (Complete with address)

Persons/organizations receiving the information: (Complete with address)

I understand that all records will be in paper format and mailed unless specified: ☐ Electronic ☐ Pick Up at Location: _____

The purpose of this request: ☑ Personal Request ☐ Treatment (Continued Care) ☐ Other: _____

Please furnish the following information specified below for the following visit dates: _____ Check appropriate boxes below:

☐ Radiology Reports
☐ Radiology Images
☐ Complete Radiology Records

Patient Signature: _____ Printed Patient Name: _____

Legally Authorized Person Signature: _____ Print Name: _____

Witness Signature: _____ Print Name: _____

Date: _____

Request for Access has been: ☐ Granted ☐ Partially Denied ☐ Denied
Medical Records released/accessed: Date of release/Access _____

Please submit this completed Request for Access and Authorization for Use and/or Disclosure of Protected Health Information to the Florida Radiology Imaging Office where you were treated.

You have the right to complain to the Office of Civil Rights. The following is the contact information:
Office of Civil Rights ~ US Department of Health & Human Services
61 Forsyth St., SW Suite 3B70 Atlanta, GA 30323