PATIENT'S NAME:_____ **SS #**:_____

ADDRESS: _____ **Date of Birth**:_____

City/State/Zip: _____ **Medical Record #**:_____

Phone: _____

I hereby request and authorize **NCH Healthcare System** to release my personal health information to: _____

_____

The information is to be: ☐ Mailed To: _____

☐ Picked Up: _____ _____ _____
By (Name) DATE TIME

I understand and acknowledge that certain information which may be contained in the medical record requires specific authorization for disclosure, and except as otherwise provided by law such information may not be disclosed without my specific consent. Additionally, I have the right to refuse disclosure and prevent any other person from disclosing such information. Such information could include: (1) treatment for mental or emotional conditions, (2) alcohol/drug abuse, and/or (3) HIV testing and/or test results.

Reason for this disclosure: _____

This authorization is for the listed date(s) of treatment: From: _____ To: _____

AN ABSTRACT OF THE MEDICAL RECORDS CONSISTS OF A DISCHARGE SUMMARY, HISTORY AND PHYSICAL, CONSULTATIONS, OPERATIVE REPORTS, X-RAYS, LABS, EKG, EMERGENCY ROOM RECORDS AND DIAGNOSTIC STUDIES.

Information to be released/disclosed (check all that apply):

☐ **Abstract:** including, mental health information, alcohol/drug abuse, HIV testing or results.
☐ Radiology **IMAGES**
☐ Cardiology/Neurology **IMAGES**
☐ Cardiac Catheterization **CD IMAGES**
☐ **Abstract:** excluding, mental health information, alcohol/drug abuse, IV testing or results.
☐ Emergency Room Record
☐ Other_____
☐ Final Summary
☐ History and Physical
☐ X-ray results
☐ Laboratory Results
☐ Operative/Cath Report(s)

I do hereby agree to release, indemnify and hold harmless, NCH Healthcare System, its officers, directors, employees, agents and members of its medical staff, from and against any claims against or liability incurred by it at any time, arising out of or in connection with the disclosure of medical information authorized by me pursuant to this consent. Signing this authorization may cause the health information used or disclosed pursuant to this authorization to no longer receive the protection of federal privacy laws.

This consent may be revoked at any time by notifying the Privacy Officer, except to the extent that the receiving facility has already taken action in reliance on it. This consent and authorization shall automatically expire six months from the date of the consent, unless revoked by the patient or patient's authorized representative prior to that time.

I further agree to pay the fees as listed to provide the information requested. The fees are waived only if the copies are forwarded to a physician office and/or healthcare provider. Initial: _____	**Fees:** Paper Record: $ 1.00 per page Radiology Images on CD/DVD: Patients: $10.00 per disc Legal: $60.00 per disc Physicians/ Healthcare provider: No Fee

_____ _____
Signature of Patient Date

_____ _____ _____
Legal Representative Relationship Date

For Department Use Only:
Released by:_____ Date: _____

Central Business Center, 2157 Pine Ridge Rd., Naples, FL 34109
Phone: (239) 624-6580 Fax: (239) 624-6561

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

HEALTH INFORMATION MANAGEMENT
NCH HEALTHCARE SYSTEM, NAPLES, FL

* 6 8 7 *

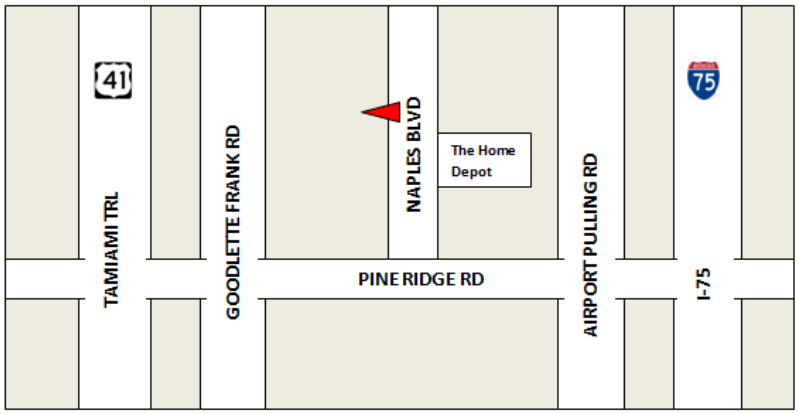
NCH#: 687 Orig: 2/98 Rev: 4/03, 12/12, 3/13, 8/14, 12/14

HealthPort has contracted with NCH Healthcare System to provide copies of your medical records to you. In an effort to serve you better, the following guidelines are applicable, in accordance with Florida State Law:

1. We must obtain **WRITTEN, SIGNED CONSENT** from the **PATIENT or LEGAL REPRESENTATIVE** (after discharge) in order for the medical records to be released.
2. When requesting medical records, the ***CURRENT AUTHORIZATION and PROPER PICTURE IDENTIFICATION are REQUIRED***.

Pursuant to **Florida State Statute 395.3025 and Florida State Code 59R-10.005**, there is a charge of **$1.00 per page** plus 6.5% sales tax and any applicable shipping and handling charges for medical records not sent ***DIRECTLY TO A PHYSICIAN OR HOSPITAL***.

*This map is not drawn to scale



NCH Healthcare System, Inc.
Health Information Mgmt.
Central Business Center
2157 Pine Ridge Rd.
Naples, FL 34109
PHONE: 239-624-6580
FAX: 239-624-6561
****Monday – Friday 8:00 am to 5:00 pm**

CARDIAC CATH LAB **(ANGIOGRAM & CATHETERIZATION FILMS)** **Downtown Naples Hospital** Phone: 239-624-2530 Fax: 239-624-2551 Monday – Friday 9:00 am to 5:00 pm ***24 HOUR ADVANCE NOTICE REQUIRED***	**CARDIO DIAGNOSTIC TEST IMAGES** **Downtown Naples Hospital** Phone: 239-624-2084 or 624-2081 Monday-Friday 8:00 am to 5:00 pm ***24 HOUR ADVANCE NOTICE REQUIRED***
NEURO DIAGNOSTIC TEST IMAGES **Downtown Naples Hospital** Phone: 239-624-2040 Monday-Friday 7:00 am to 3:30 pm ***24 HOUR ADVANCE NOTICE REQUIRED***	