PATIENT'S NAME:_____ **Date of Birth**:_____

ADDRESS: _____ **Telephone #:** _____

City/State/Zip: _____ **Email**: _____

I hereby request and authorize: ☐ **NCH Hospital** ☐ **NCH Physician Group** to release my personal health information

To release my health information to: _____ _____
(Name) (Street Address)

_____
(City, State, and Zip Code)

Please specify media type	**Paper Records:** ☐ Mail ☐ Pick-up **Electronic Records:** ☐ Secure Email ☐ CD Mail ☐ CD Pick up ☐ Portal ☐ Fax #:_____

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 sensitive 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. ☐ Do Not release my sensitive information**.

Purpose for Release: ☐ Self/Personal ☐ Continuing Care ☐ Insurance ☐ Legal ☐ Other (specify) _____

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

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

☐ Physician Office Note ☐ History & Physical ☐ Consultation Report ☐ Discharge Summary
☐ Emergency Room Report ☐ Operative Report ☐ Pathology Report ☐ Cardiology Report
☐ Laboratory Results ☐ Radiology Reports ☐ Radiology **CD** ☐ Cardiology **CD**
☐ Abstract (*includes H&P, Operative Report, Consult Reports, Test Reports, Discharge Summary)*
☐ Other (please specify) _____

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 on page 2 of the document to provide the information requested. The fees are waived only if the copies are forwarded to a physician office and/or healthcare provider. Please contact NCH Release of Information at 239-624-6567 for Radiology, Cardiology and Neurology image fee.

_____ _____
Signature of Patient Date

_____ _____ _____
Legal Representative Relationship Date

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

CONSENT FOR RELEASE OF MEDICAL INFORMATION
HEALTH INFORMATION MANAGEMENT
NCH HEALTHCARE SYSTEM, NAPLES, FL

Ciox 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:

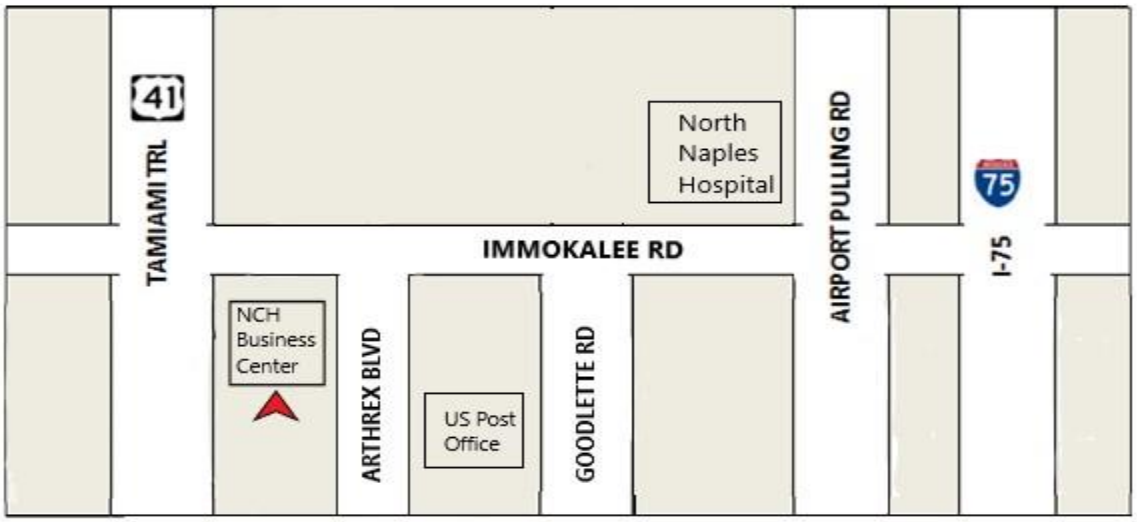
1. We must obtain **WRITTEN, SIGNED CONSENT** from the **PATIENT or LEGAL REPRESENTATIVE** (after discharge) in order for the medical records to be released.
2. When requesting medical records, the ***CURRENT AUTHORIZATION and PROPER PICTURE IDENTIFICATION are REQUIRED***. Please allow 24 hour advance notice.

Pursuant to **Florida State Statute 395.3025 and Florida State Code 59R-10.005**, there is a charge of

a. Flat fee of $6.50 per patient request
b. $.05 per page that are printed and delivered in hard copy
c. Actual postage for records that are delivered in hard copy
d. $2.00 cost to deliver the portion of record maintained in paper for a standard request

plus 6.5% sales tax and any applicable shipping and handling charges for medical records not sent ***DIRECTLY TO A PHYSICIAN OR HOSPITAL***.
Also, a fee of **$6.50 per CD** applies for Radiology, Cardiology and ECHO images.

* This map is not drawn to scale



NCH Healthcare System, Inc.
Health Information Management Department
NCH Business Center
1100 Immokalee Road, Suite 100
Naples, FL 34110
Phone: (239) 624-6567
Fax: (239) 624-6561
Monday – Friday 8:00 am to 4:30 pm