Patient's Name: ____ **Date of Birth:** ___________________________

Address: ____ **Telephone:** _____________________________

City/State/Zip: ____ **Email:** __________________________________

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

Release health information to: ____

Please Specify Release Method:	☐ Secure Email: ____ ☐ Mail: ____ ☐ Pick Up *(Address on 2nd page)* ☐ 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 authorization. **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 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):

☐ Abstract (Includes H&P, Operative Report, Consult Reports, Test Reports, Discharge Summary)	☐ Physician Office Note	☐ Consultation Report	☐ Radiology Report
	☐ Emergency Note	☐ Laboratory Results	☐ Radiology Images
	☐ History & Physical	☐ Operative Report	☐ Cardiology Report
	☐ Discharge Summary	☐ Pathology Images	☐ Cardiology Images

☐ 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 authorization. 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 authorization 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 authorization will automatically expire in one (1) year from the date signed, 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.

____________________________________ ____________________________________
Signature of Patient Date

____________________________________ ____________________ ________________
Legal Representative Relationship Date

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

NCH

TO REQUEST MEDICAL RECORDS VIA SECURE WEBSITE INSTEAD OF THIS PAPER FORM:

Scan this QR code with the camera from your phone or tablet

Datavant (CIOX) facilitates the release of NCH Healthcare System records with proper authorization. In an effort to serve you better, the following guidelines are applicable, in accordance with Florida State Law:

1. We must obtain **WRITTEN, SIGNED AUTHORIZATION** from the **PATIENT or LEGAL REPRESENTATIVE** (after discharge) for the medical records to be released. Please allow 48-hour advance notice.

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:

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***
e. A fee of **$6.50 per CD** applies for Radiology, Cardiology and ECHO images

NCH Healthcare System, Inc.
Health Information Management
NCH Business Center
1100 Immokalee Road, Suite 100
Naples, FL 34110
PHONE: 239-624-6567
FAX: 239-624-6561
EMAIL: releaseofinformation@nchmd.org

Monday – Friday 8:00 am to 4:30 pm