



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

Release health information to: _____

<i>Please Specify Release Method:</i>	<input type="checkbox"/> Secure Email: _____ <input type="checkbox"/> Mail: _____ <input type="checkbox"/> Pick Up (Address on 2 nd page) <input type="checkbox"/> 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):

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Abstract (Includes H&P, Operative Report, Consult Reports, Test Reports, Discharge Summary) | <input type="checkbox"/> Physician Office Note | <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Radiology Report |
| <input type="checkbox"/> Other (please specify): _____ | <input type="checkbox"/> Emergency Note | <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Radiology Images |
| | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Cardiology Report |
| | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pathology Images | <input type="checkbox"/> Cardiology Images |

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



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

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

HEALTH INFORMATION MANAGEMENT
NCH HEALTHCARE SYSTEM, NAPLES, FL