☐ Pick-up ☐ e-Delivery
☐ Mail Out ☐ CD ☐ MyChart

Authorization for Release of Confidential Medical Records

Medical Record#:
Account #:

1. Select location(s) from which records are to be released:

_____ Memorial Regional Hospital / Joe DiMaggio Children's Hospital
_____ Memorial Hospital West
_____ Memorial Hospital Miramar
_____ Memorial Hospital Pembroke
_____ Memorial Home Health
_____ Memorial Manor Nursing Home
_____ Memorial Regional Hospital South
_____ Memorial Hospital West Cancer Center
_____ Memorial Physician Practice(s) (specify) ____________
_____ Memorial Regional Hospital Cancer Center
_____ All Memorial Healthcare System Facilities
_____ Memorial Primary Clinic
_____ Other (specify) ____________

2. By signing this, I authorize the above to disclose protected health information about the person named below.
Patient Name (Print): ____________ Date of Birth: ____________

3. Please choose the exact information to be disclosed, including dates of service, from the options below:
_____ Abstract (An Abstract Includes only the reports identified with an * OR the specific records marked below)

	Date(s) of Service		Date(s) of Service
_____ *Face Sheet	____________	_____ *Pathology Reports	____________
_____ *Discharge Summary	____________	_____ *Consultation Reports	____________
_____ *Emergency Room	____________	_____ *EKG Reports	____________
_____ Outpatient Records	____________	_____ *Clinical Lab Reports	____________
_____ *History & Physical	____________	_____ *X-ray Reports	____________
_____ Progress Notes	____________	_____ All Medical Records	____________
_____ *Operative / Procedure Reports	____________	_____ Other (specify)	____________
_____ Newborn ID Sheet	____________		

Note: X-ray images must be obtained from the Radiology Department

4. This information is to be released to:
Name: ____________
Address: ____________
I request my records be sent to me at this e-mail address: ____________

5. I acknowledge the following statements:
   a. I understand that I may revoke this Authorization at any time by sending a written request to the privacy officers at any facility listed on the back of this form. Such revocation will not have any effect on any action taken by Memorial Healthcare System before the revocation.
   b. This Authorization will expire six (6) months from date of signature, or when revoked or on the following date: ____________
   c. I understand that this information may include information relating to: 1) Acquired Immune Deficiency Syndrome (AIDS) or Human immunodeficiency Virus (HIV) infection. 2) Mental or behavioral health or psychiatric care. 3) Treatment of drug or alcohol abuse.4) Genetic testing results.
   d. I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the party who receives it because it may no longer be protected by the federal privacy laws.
   e. I understand that records in an electronic form can be distributed on a wide scale with relative ease and losses or unintended releases of the requested information may occur under circumstances beyond the control of MHS, its release of information vendor or the person making the request. By requesting records in this format the requestor is knowingly and voluntarily assuming this risk and all consequences, losses and damages that might result.
   f. If Memorial Healthcare System has requested this Authorization, I understand that Memorial Healthcare System will give me a copy of this Authorization form after I sign it.
   g. I understand that Memorial Healthcare System may not condition treatment, payment, enrollment or eligibility of benefits on the completion of this Authorization.
   h. This information will be used / disclosed for the following purpose(s): ____________

This section also applies when Memorial Healthcare System requests the Authorization for marketing purposes only. Will MHS receive compensation for this disclosure? No ____ Yes ____ If yes, compensation will be ____________ paid by ____________ for disclosing information to ____________

Signature of patient: ____________ **Phone:** ____________ **Date:** ________ **Time:** ________
-OR-
Signature of patient's legal personal representative: ____________ **Date:** ________
Printed name of patient's representative: ____________ **Phone:** ________
Relationship to patient / authority to act for patient: ____________

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL RECORDS
2310-10173 (05/21)

PATIENT/LABEL

Authorization for Release of Confidential Medical Records

Contact Information

Attn: Release of Information/HIM Memorial Regional Hospital 3501 Johnson Street Hollywood, Florida 33021	Attn: Release of Information/HIM Joe DiMaggio Children's Hospital 3501 Johnson Street Hollywood, Florida 33021
Attn: Release of Information/HIM Memorial Regional Hospital South 3600 Washington Street Hollywood, Florida 33021	Attn: Release of Information/HIM Memorial Hospital West 703 North Flamingo Road Pembroke Pines, Florida 33028
Attn: Release of Information/HIM Memorial Hospital Miramar 1901 S.W. 172nd Avenue Miramar, Florida 33029	Attn: Release of Information/HIM Memorial Hospital Pembroke 7800 Sheridan Street Pembroke Pines, Florida 33024
Attn: Release of Information/HIM Memorial Regional Cancer Center 3501 Johnson Street Hollywood, Florida 33021	Attn: Release of Information/HIM Memorial Manor 777 S. Douglas Road Pembroke Pines, Florida 33025
Attn: Release of Information/HIM Memorial Primary Care Clinic 3501 Johnson Street Hollywood, Florida 33021	Attn: Release of Information/HIM Memorial West Cancer Center 703 North Flamingo Road Pembroke Pines, Florida 33028
Attn: Release of Information/HIM Memorial Physician Practice(s) 3501 Johnson Street Hollywood, Florida 33021	Attn: Release of Information/HIM Memorial Home Health 3501 Johnson Street Hollywood, Florida 33021

PATIENT/LABEL