BETHESDA HOSPITAL EAST 2815 S. Seacrest Blvd. Boynton Beach, FL 33435 (561) 737-7733
BETHESDA HOSPITAL WEST 9655 Boynton Beach Blvd. Boynton Beach, FL 33472 (561) 336-7000

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, ______________________________________, do hereby authorize the disclosure and release by Bethesda Hospital

TO: ______________________________________
Institution, Individual or Agency

____
Street Address

____
City State Zip Code

Information from my medical record for the following **Date(s) of Service:**

____

The question of privacy between the facility, my attending physician or other physician(s) and myself is waived. I fully understand that my medical record or information maintained in connection with the date(s) of service may contain mental health, alcohol and drug abuse, Human Immunodeficiency Virus (HIV) test results or Acquired Immunodeficiency Syndrome (AIDS) information.
The medical records or information authorized to be disclosed hereunder are privileged and confidential and may be disclosed only on my authorization, except as required by law. Once this information has been disclosed to the authorized party above, I acknowledge that it may be subject to redisclosure by the recipient and my privacy may no longer be protected. Only such records or information believed necessary for the purpose expressed shall be released and disclosed. I may inspect and arrange for photocopies of the records that are disclosed. If I refuse to sign this authorization, my medical record will not be released.

Information Requested:____
(Specify type of information)

Delivery Method: ☐ Mail ☐ Paper ☐ Fax ☐ E-mail or ☐ CD

If requesting HIV results, ☐ I acknowledge that I have received counseling regarding my HIV test results. Please check the box above.

Purpose of the Request:____

This authorization is valid for one year from the date signed or until ___________. I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting a written revocation request to the Health Information Management department. Copies are subject to fees in accordance with State/Federal regulations. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.

Patient Signature:______________________________________**Date:**______**Time:**_______
(If other than patient, state relationship.)

Date of Birth:______________ Phone #:___________________ MR#:_____________________

Witness Signature:____________________________________**Date:**_________**Time:**_______

Print Pt Name: ____________________________Discharge Date: ____________

Form #: 5830
September 2016