AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

HEALTH INFORMATION MANAGEMENT DEPARTMENT

HIM Dept. Location: Ortiz Campus, 2789 Ortiz Avenue, Bldg. E * Fort Myers, FL 33905
HIM Dept. Mailing Address: Evans Campus, 3763 Evans Avenue * Fort Myers, FL 33901
HIM Dept. Fax #: 239-275-4295

PATIENT NAME_____ DATE OF BIRTH_____

AUTHORIZATION FOR (check as appropriate): ____REQUEST FOR INFORMATION ____RELEASE OF INFORMATION

I authorize SalusCare to request/release information and/or records of the individual named above.

I understand that my clinical record may include information relating to HIV/AIDS, behavioral or mental health services, and/or substance abuse services (42 CFR).

This information may be released to/requested from the following:

(1)Facility/Person_____
Address_____
The information and records are for the purpose of_____
Information to be released includes (check one):
____all information
____specific information/reports, such as_____

I understand that I have a right to cancel this authorization at any time by presenting my written cancellation to the Health Information Mgt. Dept. I understand that the cancellation will not apply to information that has already been released in response to this authorization. I understand that the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I do not cancel this authorization, it automatically expires as follows:

PLEASE INITIAL ONE CHOICE:
_____Six months after the date on which my treatment is completed
_____On _____/_____/_____
_____One time only for current records/information

I understand that authorizing the disclosure of this information is voluntary. I do not need to sign this form in order to receive treatment. I understand that the above information may be disclosed by the recipient of the information. Most health care providers and insurance plans must follow federal rules protecting the privacy of health information. However, SalusCare cannot guarantee that others receiving the information will protect it.

_____ _____
Patient or Legal Representative Signature Date

_____ _____
If Signed by Legal Representative, Describe Relationship to Patient Witness Signature

PATIENT NAME:	CASE #: