Indian River Medical Center
Medical Records/HIM Department
1000 36th Street
Vero Beach, FL 32960
Phone: (772) 567-4311 x 1356 Fax: (772) 563-4723

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please Print

Last Name_____ First Name_____ Middle Name_____
Date of Birth _____Address_____ City _____
State _____ Zip _____Contact Phone ( ) _____

I hereby authorize Indian River Medical Center or other Healthcare Provider to □ release/□ obtain protected health information, including copies of the medical record of the above named patient □ to/□ from the following:

Name of Person/Facility _____
Street _____ City _____ State _____ Zip _____
Contact Phone _____ Fax _____

Purpose for Release: □ *Continuation of Medical care* □ *Personal* □ *Legal* □ *Insurance* □ *Disability* □ *School*
Is the request for PHI for the purpose of marketing and/or does it involve the sale of PHI? □ *Yes* □ *No*
Will the recipient receive financial remuneration in exchange for using or disclosing this information? □ *Yes* □ *No*

Information to be released

Requests for Radiology and Cardiology Images on CD and Radiation Oncology records (paper copies only) must be made directly to each of those departments. Copies of medical records can be provided: □ On paper (the following require separate waiver) □ CD □ USB Flash drive □ Via email. You may view your medical record on site by appointment only. Contact the HIM/Medical Records department to schedule an appointment.

I request the following:

□ Office Visit(s) Date(s) _____ Specific Provider _____
□ Lab Result
Date(s) _____ □ Radiology Date(s) _____
□ Abstract of Record - Includes all dictated reports and test results
□ Complete Medical Record □ Other – Please specify _____

Release of Information Requiring Specific Consent:

The following categories of information may be included in your medical record and WILL NOT be released unless you indicate specific authorization by **INITIALING** each appropriate category.

_____ Abortion _____ Behavioral/Mental Health _____ Alcohol/Drug Abuse _____ Domestic Violence
_____Sexual Assault _____ Genetic Testing _____Sexually Transmitted Disease _____ HIV/AIDS Results/Treatment

I understand that:

- I may revoke this authorization at any time by submitting a written notice to IRMC at the address listed above. The revocation will be effective upon IRMC receipt of my written notice, except that it will not have any effect on any action already taken by IRMC in reliance on this authorization.
- Once IRMC has disclosed my health information to the recipient, IRMC cannot guarantee that the recipient will not disclose my health information to a third party and it may no longer be protected by the HIPAA privacy rule.
- This authorization will automatically expire in 6 (six) months unless otherwise specified.
- I may refuse to sign this authorization and that is strictly voluntary.
- If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
- I will receive a copy of this signed authorization.

_____ _____
Signature of Patient or Authorized Representative Date

You MUST provide/attach proof of your authority to act on behalf of the patient (other than parent).
You MUST provide/attach a picture identification to validate your identity. ____Government issued ID, ___passport, or ____driver's license.

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Medical Center

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AUTHORIZATION TO RELEASE MEDICAL RECORDS ELECTRONICALLY

Disclaimer regarding ROI form (for email or electronic format):

I understand that the CD or USB flash drive is not encrypted or password protected and that it is my responsibility to take extra precautions to protect the data on the device and not to lose or misplace the device. Additionally, I understand that unencrypted e-mail is not secure – that means it could be intercepted and seen by others; in addition, I understand that there are other risks with unencrypted e-mail including misaddressed/misdirected messages; e-mail accounts that are shared; messages forwarded to others; and messages stored on portable devices having no security. By choosing to receive my health information on a CD or USB flash drive or by unencrypted e-mail, I am acknowledging and accepting these risks.

_____ _____

Signature of Patient or Authorized Representative Date

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