Cleveland Clinic
Indian River Hospital

Cleveland Clinic Indian River Hospital
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 Cleveland Clinic Indian River Hospital 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:

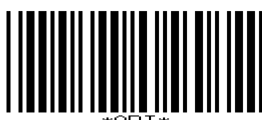
- I may revoke this authorization at any time by submitting a written notice to Cleveland Clinic Indian River Hospital at the address listed above. The revocation will be effective upon CCIRH receipt of my written notice, except that it will not have any effect on any action already taken by CCIRH in reliance on this authorization.
- Once Cleveland Clinic Indian River Hospital has disclosed my health information to the recipient, CCIRH 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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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