Tampa HCA Shared Service Center – HSC Release of Information
6451 126th Avenue North, Largo FL 33773
Phone (727) 773-3268

Stat/Continuity of Care Requests Only, Fax to 1-855-446-6008

Section A: This section must be completed for all Authorizations

Patient Name:	**Date of Birth:**	**Patient's Phone:**	**Last 4 digit SSN: (optional)**

Recipient's/Provider's Name:

Address 1:	**Address 2:**	**Recipient's Phone:**
City:	**State:**	**Zip:**

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.*, USB drive, CD/DVD)** ☐ **Encrypted Email** ☐ **Unencrypted Email**

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.*, paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.*, virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.) If no date is entered, the authorization will expire 30 days from the date signed. **Date:** **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes?
☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.
☐ No, then you may check as many items below as you need.

Hospital to release records from:

☐ Blake Medical Center	☐ Englewood Community Hospital	☐ Reg Med Center of Bayonet Point
☐ Brandon Regional Hospital	☐ Fawcett Memorial Hospital	☐ South Bay Hospital
☐ Medical Center of Trinity	☐ Largo Medical Center	☐ St. Petersburg General Hospital
☐ Doctors Hospital of Sarasota	☐ Northside Hospital	
☐ Edward White Hospital	☐ Oak Hill Hospital	

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ Entire Medical Record		☐ Clinical Test		Super-Confidential Information	
☐ Abstract (most common)		☐ Medication Sheets		☐ HIV Testing Documentation	
☐ Physician Orders		☐ ED Information		☐ HIV & AIDS Documentation	
☐ Physician Progress Notes		☐ Admission Form		☐ Psychiatric Documentation	
☐ Physician Dictated Reports		☐ Operative Documentation		☐ Alcohol & Drug Abuse Doc	

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ No
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:
May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**