PALM BEACH GARDENS MEDICAL CENTER
PALM BEACH HEALTH NETWORK

Rev 03/23 PBGNDA

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:	Last First Middle
Home Address:	
Home Telephone:	
Date of Birth:	

Specify Information to be Disclosed:

□ Face Sheet	□ Pathology	□ ER	□ Stress Test Rep
□ Discharge Summary	□ Radiology Reports	□ Orders	□ Holter Monitor Rep
□ History & Physical	□ EKG	□ Progress Notes	□ Respiratory
□ Consultations	□ Laboratory	□ Rehab (PT,OT,ST)	□ Medications
□ Operative Reports	□ Echo	□ EEG	□ Biopsychosocial Ax
□ Mammogram Reports	□ Treatment Records	□ Treatment Plan	□ Psych Ax
□ Psychological Testing	□ HIV/ARC/AIDS related information		__ Itemized Bills
__ Abstract	__ Entire Chart		__ Radiology Films

□ Other _____

_____

By applying a check next to a category of highly confidential information listed below and signing on the appropriate line after the checked box, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization:

□ Mental Illness _____
□ Developmental Disability _____
□ Psychotherapy Notes _____
□ HIV/AIDS Testing or Treatment (regardless of result) _____
□ Venereal Disease _____
□ Abuse of an Adult with a Disability _____
□ Sexual Assault _____
□ Child Abuse or Neglect _____
□ Genetic Testing _____
□ Other _____

_____

RECIPIENT: **Name of person or class of persons to whom Palm Beach Gardens Medical Center may disclose my health information:** _____

_____

Select Delivery Method:

Pick Up Paper: ____ Pick up CD: ____

Fax to Dr : _____ Patient Email: _____

Mailing Address: _____

TERM: **This Authorization will remain in effect:**

- ☐ From the date of this Authorization until the ___ day of _____, 202__.
- ☐ Until Covered Entity fulfills this request.
- ☐ Until the following event occurs _____
- ☐ Other _____

If no date or event is specified, this release will expire in ninety (90) days.

PURPOSE: I authorize Palm Beach Gardens Medical Center to use or disclose my health information (including the highly confidential I selected above, if any) during the term of this Authorization for the following specific purpose(s): Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization:

_____

_____

I understand that once Palm Beach Gardens Medical Center discloses my health information to the recipient, Palm Beach Gardens Medical Center cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that Palm Beach Gardens Medical Center may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Palm Beach Gardens Medical Center; except, however, if my treatment at Palm Beach Gardens Medical Center is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Palm Beach Gardens Medical Center may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Palm Beach Gardens Medical Center's Privacy Office at the address listed below. The revocation will be effective immediately upon Palm Beach Gardens Medical Center's receipt of my written notice, except that the revocation will not have any effect on any action taken by Palm Beach Gardens Medical Center in reliance on this Authorization before it received my written notice of revocation.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Palm Beach Gardens Medical Center to use or disclose my health information in the manner described above.

_____ _____

Signature of Patient **Date/Time**

If patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____

Signature of Personal Representative **Description of Authority** **Date/Time**

For Internal Use Only: The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the PHI records.

_____

Signature of employee validating identity

FOR OFFICE USE ONLY

Print Name _____

Phone _____

Signature accepting charges _____

Date _____