



Health Information Management Dept.  
P.O. Box 1289  
Tampa, FL 33601-1289  
Phone: (813) 844-7525

## Authorization To Disclose Health Information

Patient Name \_\_\_\_\_  
Last First Middle Initial

Street Address \_\_\_\_\_ Apt \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ SSN \_\_\_\_\_

**The undersigned hereby authorizes and requests Tampa General Hospital to provide to:**

\_\_\_\_\_ Identity of Third Party or Authorized Representative / Name of Health Care Facility

Street Address \_\_\_\_\_ Suite/Floor \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Check the box next to each type of information to be disclosed (include dates where indicated):**

- Most recent history and physical or specific date(s) \_\_\_\_\_
- Most recent discharge summary or specific date(s) \_\_\_\_\_
- Consultation reports, specify date(s) \_\_\_\_\_
- Laboratory results, specify types or dates \_\_\_\_\_
- Other diagnostic testing results, specify types or dates \_\_\_\_\_
- Entire record, specify date \_\_\_\_\_
- Other, specify \_\_\_\_\_
- No limitations placed on dates, history of illness, or diagnostic and therapeutic information for treatment for alcohol and drug abuse as protected by Federal Regulation 42CFR, Part II; psychiatric / psychological information and HIV/AIDS related information including testing per FS 90.503, 381.004, and 394.459.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department or mail to the above address. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of health information, I can contact the Director of the Health Information Management Department at (813) 844-7525.

**Unless otherwise revoked, this authorization will expire on the following date, event or condition:**

\_\_\_\_\_

If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.

\_\_\_\_\_  
Signature of Patient or Legal Representative Signature of Witness

\_\_\_\_\_  
If signed by Legal Representative, Relationship to Patient Date