

**Authorization for Request of Medical Record Information and  
Full Disclosure of Health Information for Treatment & Quality of Care**

Patient name: \_\_\_\_\_  
Last First Middle Birth Date Age

Address: \_\_\_\_\_  
Street City State Zip Social Security Number

The purpose for disclosing this information is to provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure to all informational sources:

1. All my health information in both paper and electronic format regarding my health history, treatment, hospitalizations, test, and outpatient care. This information includes but is not limited to:
  - Drug, alcohol, or substance abuse.
  - Psychological, psychiatric or other mental impairments.
  - Records which indicate the presence of communicable disease test for or records related to HIV or sexually transmitted diseases.
  - Genetic diseases or test.
2. This information may be shared with other hospitals, clinics, pharmacies, mental health facilities, state registries, health information exchanges (HIE), regional health information organizations (RHIO), accountable care organizations (ACO) and other federal or state programs or agencies. Information may be shared with health care providers which would include physicians, nurses and other medical staff involved in my care, and demographics about the encounter of care rendered.
3. In Addition:
  - I authorize the use of a copy of this form for disclosure of the information described above.

I have read all of this form and agree to the disclosures above.

I hereby grant TAMPA GENERAL HOSPITAL and its affiliates to share my records with: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**I also hereby authorize and request:**

\_\_\_\_\_  
Name of Health Care Facility

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

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

**to release medical, psychiatric, alcohol, AND/OR substance abuse information contained in subject's medical records for the purpose of continued care to: Tampa General Hospital, P.O. Box 1289, Tampa, Florida, 33601-1289, Fax: \_\_\_\_\_ (813-844-6677 if blank)**

The foregoing is subject to such limitations as indicated below:

1. Confined to records regarding admission and treatment for the following medical condition or injury:  
\_\_\_\_\_
2. Covering records for the period from \_\_\_\_\_ to \_\_\_\_\_
3. Confined to the following specific information: \_\_\_\_\_
- \_\_\_\_\_
4. No limitations placed on dates, history of illness, or diagnostic and therapeutic information, including any treatment for alcohol and drug abuse as protected by Federal Regulation 42CFR, Part II; psychiatric/psychological information and AIDS-related information including testing, FS 394.459,490.32 and / or 90.503, 381,609.

**This authorization / permission form will remain in effect for life or the day I withdraw my permission.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

