Tenet Florida Physician Services II, LLC
901 45th St. Kimmel Bldg., West Palm Beach, FL 33407-2413
Office: (561) 844-5255 Fax: (561) 844-5245

RECORD RELEASE or REQUEST/ AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name: _____
First Middle Last

Home Address: _____

Home Telephone: _____ Date of Birth: _____

SPECIFY INFORMATION TO BE RELEASED OR REQUESTED (CIRCLE WHICH): The information that may be released or requested (circle which) under this Authorization includes:

☐ Discharge Summary	☐ Progress/ Physician Notes	☐ X-Ray Report	☐ Pathology Report
☐ History & Physical	☐ Nurses Notes	☐ EKG/EMG/ EEG Report	☐ Consult Report
☐ Emergency Report	☐ Laboratory Report	☐ Operative Report	☐ Entire Record

☐ Other: _____

Records for the period (dates) from_____to_____

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/ or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

- ☐ Information about mental health or mental retardation services
- ☐ Psychotherapy Notes created by a mental health professional
- ☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- ☐ Information about sexually transmitted diseases
- ☐ Information about alcohol or drug abuse treatment program services
- ☐ Information about sexual assault
- ☐ Information about child abuse and neglect

RELEASE information TO: _____

Name: _____

Address: _____

City: State: Zip Code: _____

Telephone: Fax: _____

RELEASE Information From: _____

Name: _____

Address: _____

City: State: Zip Code: _____

Telephone: Fax: _____

TERM: This Authorization will remain in effect:

- ☐ From the date of this authorization until the _____ day of _____, 20_____.
- ☐ Until TENET FLORIDA PHYSICIAN SERVICES II, LLC fulfills this request.
- ☐ Until the following event occurs: _____
- ☐ Other:_____

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PURPOSE: I authorize TENET FLORIDA PHYSICIAN SERVICES II, LLC to use or disclose my health information (including the highly confidential information 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].

RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I understand that once TENET FLORIDA PHYSICIAN SERVICES II, LLC discloses my health information to the recipient, TENET FLORIDA PHYSICIAN SERVICES II, LLC cannot guarantee that the recipient will not redisclose 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 TENET FLORIDA PHYSICIAN SERVICES II, LLC may, directly or indirectly, receive remuneration from a third party in connection with the use of 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 TENET FLORIDA PHYSICIAN SERVICES II, LLC; except, however, if my treatment at TENET FLORIDA PHYSICIAN SERVICES II, LLC is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case TENET FLORIDA PHYSICIAN SERVICES II, LLC 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 TENET FLORIDA PHYSICIAN SERVICES II, LLC's Privacy Office at the address listed below. The revocation will be effective immediately upon TENET FLORIDA PHYSICIAN SERVICES II, LLC's receipt of my written notice, except that the revocation will not have any effect on any action taken by TENET FLORIDA PHYSICIAN SERVICES II, LLC in reliance on this Authorization before it received my written notice of revocation.

I understand that there may be a charge for producing record copies according to state regulations.

I may contact TENET FLORIDA PHYSICIAN SERVICES II, LLC's Privacy Office at:

Corporate Compliance & Privacy Office
Tenet Healthcare
1445 Ross Avenue, Suite 1400
Dallas, Texas 75202
E-mail: PrivacySecurityOffice@tenethealth.com
Ethics Action Line (EAL) 1-800-8-ETHICS

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, I hereby, knowingly and voluntarily authorize TENET FLORIDA PHYSICIAN SERVICES II, LLC to use or disclose my health information in the manner described above.

Signature:_____ Date:_____

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

Signature of Authorized Personal Representative	Relationship to Patient	Date
_____	_____	_____