

AUTHORIZATION FOR RELEASE OF PSYCHIATRIC HOSPITALIZATION INFORMATION

I, _____, hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Psychiatric Medical Record _____

Psychiatric Discharge Summary _____

I authorize this release of information to:

Patient
(List current address and phone number)

University of Central Florida Health Services
H I M Department
P.O. Box 163333
Orlando, FL 32816-3333

- I understand that I may see and copy the information described on this form if I ask for it and that I get a copy of this form after I sign it.
- I understand that this authorization will expire 90 days from date signed.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any affect on any actions they took before they received the revocation.

Patient Signature

Date

Print Name

Social Security Number

Witness

Date

Copied/Sent By

Date

SENT: ____ Yes ____ No FAXED: ____ Yes ____ No HANDCARRIED: ____ Yes ____ No
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