ORLANDO HEALTH® | South Lake Hospital

Instructions for Requesting Medical Records At South Lake Hospital

Only the patient or the patient's legal representative can authorize a release of medical records. All requests must include a copy of photo identification and proof of legal representation as appropriate.

1. Print the form.

2. Please complete highlighted areas:
    a. Patient name
    b. Patient date of birth
    c. Service date for records requested
    d. Please indicate if prefer records to be Mailed, Faxed, or for Pick-Up
    e. ***Name of Facility or Person***, write "self" or the name of the person, doctor or facility records are to be release to
    f. ***Purpose of Release*** – **Initial** purpose of record request
    g. ***Specific Medical Reports to be Disclosed*** - **Initial** the type of records requested
        i. **IMPORTANT – must be initialed to release records.**
    h. Sign and date

3. Provide a copy of or bring patient's photo ID

4. Fax, mail, or drop off completed form
    a. Hours of Operation - Monday through Friday, 8 AM – 5 PM.
    b. Mailing address:
        South Lake Hospital
        Attention: Medical Records
        1900 Don Wickham Drive
        Clermont, FL 34711
    c. Fax number 321.843.6291
    d. Medical Records Phone 352. 394.4071 ext 8141
    e. Radiology Films Phone .352.394.4071 ext 8157

ORLANDO HEALTH® | South Lake Hospital

AUTHORIZATION FOR RELEASE OR REVIEW OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT IDENTIFICATION

Patient Name: _____ Phone: _____

Address: _____

Date of Birth: _____/_____/_____ Date of Service: _____ Identification Shown: _____

❑ Mail ❑ Fax ❑ Secure Email or Pick-Up: ❑ Paper ❑ CD Pick-up date/time: _____

Email Address_____

I hereby authorize South Lake Hospital to use and **disclose to ❑ or allow review ❑**

_____ _____ _____

Name of Facility or Person Phone Fax

_____

Street Address City State Zip Code

The purpose for the release of information at the request of the individual is (INITIAL):

_____Continued Treatment _____Personal Use _____Patient Communication (Behavioral Health)

_____Insurance _____Legal Action _____Other, please specify_____

The specific Medical Reports to be disclosed shall include: INITIAL each that applies.

_____Abstract (ED, H&P, CR, Operatives, Consults, Diagnostic, Pathology)
_____Emergency/Urgent Care
_____Discharge Summary (Clinical Resume)
_____Operative Reports
_____Pathology Report(s)
_____Consultation
_____Progress Notes
_____Complete Record

_____All Diagnostic Test Results
_____Lab Reports Only
_____Therapy Records
_____Radiology Reports Only
_____Radiology Images Only
Specific Images: _____
_____
_____Other (specify)_____

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initialed below or otherwise required by law.

May **NOT** include information related to **(please initial):**

____ HIV/AIDS ____ Mental Health ____ Drug and/or Alcohol Abuse ____ Genetic Counseling/Testing Information

If I fail to specify an expiration event or condition, **the authorization will expire in one year**. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that Orlando Health may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization. I understand that I will receive a signed copy of this form.

_____ Date: _____ Time: _____

Patient/Legal Representative or Parent/Legal Guardian Signature

Official Use Only:

_____ Date: _____ Time: _____

❑ Name of Person Releasing Information ❑ Name of Person Assisting with Reviewer

❑ **I wish to revoke this authorization**. Signature: _____ Date: _____ Time: _____