PATIENT'S NAME:______________________________ **Date of Birth**:______________________

ADDRESS: ______________________________ **Medical Record #**:______________________

City/State/Zip: ______________________________ **Phone**: ______________________

I hereby request and authorize **NCH Healthcare System** to release my personal health information to: ______________________

____

The information is to be: ☐ Mailed To: ____

☐ Picked Up: ______________________ ______________________ ______________________
By (Name) DATE TIME

I understand and acknowledge that certain information which may be contained in the medical record requires specific authorization for disclosure, and except as otherwise provided by law such information may not be disclosed without my specific consent. Additionally, I have the right to refuse disclosure and prevent any other person from disclosing such information. Such information could include: (1) treatment for mental or emotional conditions, (2) alcohol/drug abuse, and/or (3) HIV testing and/or test results.

Reason for this disclosure: ____

This authorization is for the listed date(s) of treatment: From: ______________________ To: ______________________

AN ABSTRACT OF THE MEDICAL RECORDS CONSISTS OF A DISCHARGE SUMMARY, HISTORY AND PHYSICAL, CONSULTATIONS, OPERATIVE REPORTS, X-RAYS, LABS, EKG, EMERGENCY ROOM RECORDS AND DIAGNOSTIC STUDIES.

Information to be released/disclosed (check all that apply):

☐ **Abstract:** including, mental health information, alcohol/drug abuse, HIV testing or results.
☐ Radiology **CD IMAGE**
☐ Cardiology/Neurology **CD IMAGE**
☐ Cardiac Catheterization **CD IMAGE**

☐ **Abstract:** excluding, mental health information, alcohol/drug abuse, IV testing or results.
☐ Emergency Room Record
☐ Other______________

☐ Final Summary
☐ History and Physical
☐ Radiology results
☐ Laboratory Results
☐ Operative/Cath Report(s)

I do hereby agree to release, indemnify and hold harmless, NCH Healthcare System, its officers, directors, employees, agents and members of its medical staff, from and against any claims against or liability incurred by it at any time, arising out of or in connection with the disclosure of medical information authorized by me pursuant to this consent. Signing this authorization may cause the health information used or disclosed pursuant to this authorization to no longer receive the protection of federal privacy laws.

This consent may be revoked at any time by notifying the Privacy Officer, except to the extent that the receiving facility has already taken action in reliance on it. This consent and authorization shall automatically expire six months from the date of the consent, unless revoked by the patient or patient's authorized representative prior to that time.

I further agree to pay the fees as listed on page 2 of the document to provide the information requested. The fees are waived only if the copies are forwarded to a physician office and/or healthcare provider. Please contact NCH Release of Information at 239-624-6567 for Radiology, Cardiology and Neurology image fee.

______________________________ ______________________________
Signature of Patient Date

______________________________ ______________________ ______________________
Legal Representative Relationship Date

For Department Use Only:
Released by:______________________________ Date: ______________________________

Central Business Center, 2157 Pine Ridge Rd., Naples, FL 34109
Phone: (239) 624-6567 Fax: (239) 624-6561
SEE PAGE 2 FOR DIRECTIONS AND BUSINESS HOURS

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

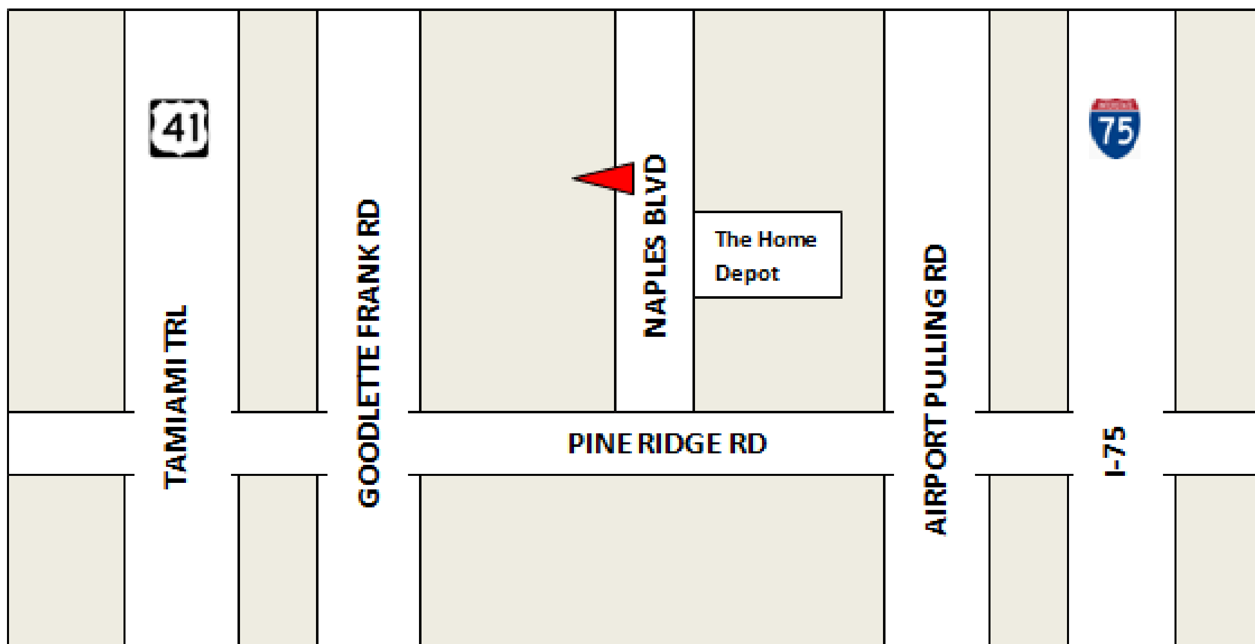
HEALTH INFORMATION MANAGEMENT
NCH HEALTHCARE SYSTEM, NAPLES, FL

HealthPort has contracted with NCH Healthcare System to provide copies of your medical records to you. In an effort to serve you better, the following guidelines are applicable, in accordance with Florida State Law:

1. We must obtain **WRITTEN, SIGNED CONSENT** from the **PATIENT or LEGAL REPRESENTATIVE** (after discharge) in order for the medical records to be released.
2. When requesting medical records, the ***CURRENT AUTHORIZATION and PROPER PICTURE IDENTIFICATION are REQUIRED***. Please allow 24 hour advance notice.

Pursuant to **Florida State Statute 395.3025 and Florida State Code 59R-10.005**, there is a charge of **.39¢ per page** plus 6.5% sales tax and any applicable shipping and handling charges for medical records not sent ***DIRECTLY TO A PHYSICIAN OR HOSPITAL***. Also, a fee of **$10.00 per CD** applies for Radiology, Cardiology and ECHO images.

*This map is not drawn to scale



NCH Healthcare System, Inc.
Health Information Mgmt.
Central Business Center
2157 Pine Ridge Rd.
Naples, FL 34109
PHONE: 239-624-6567
FAX: 239-624-6561
Monday – Friday 8:00 am to 5:00 pm