SOUTH LAKE HOSPITAL

In partnership with
ORLANDO HEALTH

PATIENT IDENTIFICATION

AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

I, ____ hereby authorize South Lake Hospital to obtain Records of
Patient / Legal Representative
Protected Health Information for ____
From:

____
Name of Individual, Healthcare Facility or Agency
____
Address
____
City State Zip
____
Phone Number

To: **The PUR Clinic/South Lake Hospital**
Fax: (321) 843-2120
1920 Don Wickham Drive, Suite 130
Clermont, FL 34711
Phone: 352-536-8761

For the purpose of: ☒Continued Treatment ☐Personal Records
☐Other (please specify) ______________________________________

Date(s) of Service: From: ________________ To: ________________

This authorization will expire on the following date, event or condition: ______________________
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. Mental health, alcohol, drug, HIV and or AIDS information is confidentially protected by Federal and State law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/testing information in my record by released without my written authorization, except as otherwise required by law. **I understand that I may select the information from the list below to be released by placing my initials in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized redisclosure of my health information.** I further understand that South Lake Hospital may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

Place your initials by each item to be released or reviewed:

_____ Complete Record
Or
_____ Abstract Record

_____ All diagnostic test results
_____ Therapy Records
_____ Consultation/Progress Notes
_____ Radiology Only

_____ Pathology/Operative Report(s)
_____ Lab only
_____ Other (please specify)
____

In addition, place your initials by each specific item: (if applicable)
_____ Mental Health
_____ Drug and/or Alcohol
_____ HIV Testing
_____ AIDS Information
_____ Genetic Counseling/Testing Information

____ ________________ _____
Patient/Legal Representative or Parent/Legal Guardian Signature Date of Authorization Time

________________ ________________________ ________________________
Patient's Date of Birth Patient's Social Security # Identification Shown

____
Address City State Zip Code

____ ________________________
Telephone Number Translator or Interpreter's Name

☐ **I wish to revoke this authorization**
Patient Signature: _________________________________ Date: ______________ Time:__________

Official Use Only: ___________________________________ Date: _______________ Time: __________
☐ Name of Person releasing information ☐ Name of person assisting with review Number of pages copied _____