Tampa HCA Shared Service Center – HSC Release of Information
6451 126th Avenue North, Largo, FL 33773
Phone (866) 463-7272 Email: HSCT.MRRequest@Parallon.com

Stat/Continuity of Care Requests Only, Fax to 1-855-446-6008

Section A: This section must be completed for all Authorizations

Patient Name:	**Date of Birth:**	**Patient's Phone:**	**Last 4 digit SSN:** (optional)

Recipient's Name: RECORDS DEPOSITION SERVICE, INC.

Address 1: PO BOX 5054	**Address 2:**	**Recipient's Phone:** 248-357-3330
City: SOUTHFIELD	**State:** MICHIGAN	**Zip:** 48086-5054

Request Delivery (If left blank, a paper copy will be provided): ☐ Paper Copy ☐ Electronic Media, if available (*e.g.,* USB drive, CD/DVD)
☑ Encrypted Email ☐ Unencrypted Email ☐ Provider Fax Number____________

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.,* paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.,* virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly): REQUESTS@RECDEP.COM

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**

Purpose of disclosure: LEGAL - DISCOVERY BEFORE TRIAL

Hospital to release records from:

☐ Blake Medical Center	☐ Edward White Hospital	☐ Medical Center of Trinity	☐ Palms of Pasadena
☐ Brandon Regional Hospital	☐ Englewood Community Hospital	☐ Memorial Hospital of Tampa	☐ Reg Med Center of Bayonet Point
☐ Citrus Memorial Hospital	☐ Fawcett Memorial Hospital	☐ Northside Hospital	☐ St. Petersburg General Hospital
☐ Doctors Hospital of Sarasota	☐ Largo Medical Center	☐ Oak Hill Hospital	☐ South Bay Hospital
			☐ Tampa Community Hospital

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ Abstract (most common)		☐ Operative information		☐ Labor/delivery summary	
☐ Entire medical record		☐ Cath lab		☐ OB nursing assess	
☐ Admission form		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Dictation reports		☐ Rhythm strips		☐ Itemized bill:	
☐ Physician orders		☐ Nursing information		☐ UB-04:	
☐ Intake/outtake		☐ Transfer forms		☐ Other:	
☐ Clinical test/radiology result		☐ ER information		☑ Other: PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST	
☐ Medication sheets					

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. ____________ (Initial)

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I can get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ No
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial payment in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:
May the recipient of the PHI further exchange the information for financial payment? ☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

ID verified by: ___________ (Initials)

Authorization for Release of PHI

ROI HCA05028 Rev. 3/2016

Patient Label