Tampa General Hospital (TGH)

Health Information Management Dept.
P.O. Box 1289
Tampa, FL 33601-1289
Phone: (813) 844-7533

Tampa General Medical Group (TGMG)

Authorization to Disclose Health Information

Required: Release records from which TGH/TGMG location:____________________

Patient Name____________________ ________________ __________

Last First Middle Initial

Street Address____________________ Apt__________

City____________ State_____ Zip________ Birth date________ Age____

Home Phone____________ Work Phone____________ SSN____________

Email address:____________________

The undersigned hereby authorizes and requests Tampa General Hospital and/or Tampa General Medical Group to provide to:

Records Deposition Service

Identity of Third Party or Authorized Representative / Name of Health Care Facility

Street Address P.O. Box 5054 Suite/Floor__________

City Southfield State MI Zip 48086-5054 Phone (248) 357-3330 F (248) 357-3337

Per Federal and State regulations, hospitals are authorized to charge up to a $1.00 per page for copies of medical records.

Check the box next to each type of information to be disclosed (include dates where indicated):

- ☐ Most recent history and physical or specific date(s):____________________
- ☐ Most recent discharge summary or specific date(s):____________________
- ☐ Laboratory results, specify types or dates:____________________
- ☐ Other diagnostic testing results, specify types or dates:____________________
- ☐ Entire record, specify date:____________________
- ☐ Abstract, specify date (includes only pertinent treatment information):____________________
- ☐ Other, specify:____________________
- ☐ Including HIV/AIDS testing, results, and/or treatment records; Mental Health treatment records (excluding psychotherapy notes); alcohol and/or drug abuse treatment records

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department or mail to the above address. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of health information, I can contact the Director of the Health Information Management Department at (813) 844-7525.

Unless otherwise revoked, this authorization will expire on the following date, event or condition:

____

If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.

____________________ ____________________

Signature of Patient or Legal Representative **Signature of Witness**

____________________ ____________

If signed by Legal Representative, Relationship to Patient **Date**