North Orlando Surgical Group
Excellence is our standard of care

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Today's Date: ________________________________ Patient's SSN: ____________________________

Patient Name: ________________________________ Date of Birth: ____________________________

Address: ____

Preferred Phone Number for Contact: ____

Describe the information you approve disclosure of:

☐ All aspects of my healthcare as allowed to me under applicable law.
☐ Other: ____

To whom you approve disclosure (spouse, family, friend...):

Name: ________________________________ Relationship: ________________Phone: ____________________
Address:______________________________ City: __________________ State: _____ Zip Code: ______________

Name: ________________________________ Relationship: ________________Phone: ____________________
Address:______________________________ City: __________________ State: _____ Zip Code: ______________

Name: ________________________________ Relationship: ________________Phone: ____________________
Address:______________________________ City: __________________ State: _____ Zip Code: ______________

- I understand that I still have a right to access my PHI as allowed under applicable law.
- I understand that I may receive an accounting of disclosures as explained in North Orlando Surgical Group's Notice of Patient Privacy Practices.
- I understand that my PHI may be disclosed for public policy purposes as stated in the North Orlando Surgical Group's Notice of Patient Privacy Practices.
- I understand that North Orlando Surgical Group may terminate its agreement to use or disclose any of my PHI at any time but only after I have received notice of such termination.

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written authorization to North Orlando Surgcial Group Medical records department. I understand that my revocation will not apply to information already released in response to this authorization.

Signature of Patient: ______________________________________ Date: __________________

~OVER~

Patient Consent Form for Electronic Exchange of Individual Health Information (HIE)

CONSENT

Signing the consent form means that you are allowing your own electronic health information to be used by health care providers at participating centers and clinics only to provide you with medical treatment and support public health projects.

Sharing your own electronic health information in a health information exchange is your choice. Health care providers will provide you with medical care even if you decide not to share your own electronic health information in the exchange. Your insurance eligibility will not change based on your decision to share your own electronic health information in the health information exchange.

PURPOSE

This consent form allows for the exchange of your medical information with external hospitals and practices to enhance your care coordination, treatment planning, and continuity of care. Sharing your own electronic health information will allow your health care provider to review all your medical history and treatments. This will help your health care provider to make better informed decisions about your medical care.

TYPES OF INFORMATION INCLUDED IN THIS CONSENT

If you give consent, any participating HIE organization may view and share ALL your electronic health information available through any connected health information exchange. This includes information created before and after the date of your consent form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like x-rays or blood tests), and medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

- Alcohol or substance abuse records
- Inherited or genetic conditions
- Mental health conditions
- Birth control, abortion and family planning
- HIV
- Lab results
- Sexually transmitted diseases

My Consent Choices (CHECK ONE):

- ○ **Opted In: Send and Receive Documents. I consent to both send and receive my medical documents with external hospitals and practices.**
- ○ **Opted In: Receive Documents Only. I consent to receiving my medical documents from external hospitals and practices but do not permit the sending of my documents.**
- ○ **Opted In: Send Documents Only. I consent to send my medical documents to external hospitals and practices but do not permit the receiving of documents.**
- ○ **Opted Out: I do not consent to any data exchange with external hospitals and practices.**

Acknowledgment:

I understand that by consenting to the selected option, my medical information may be shared with authorized external healthcare providers. I also understand that I can revoke this consent at any time by notifying my healthcare provider in writing.

Patient Signature: ____ **Date:** _________________________

If signed by someone other than the patient, print name and indicate relationship:

Authorized Representative: __________________________ **Relationship:** __________ **Date:** _______________