Omega Health & Wellness
Look no further…

Authorization for Release of Protected Health Information

I authorize the following facility(s) to release health information from the record of:

____

as described below to: (Patients Name) ____

Date of Birth: ___________________________ Last four of SSN# _________________________

Name of Facility/Person ____

Phone:__________________________________ Fax: _______________________________________
Authorization to release confidential information regarding my medical status to:

Omega Health & Wellness:
8761 Perimeter Park Blvd #101
Jacksonville, FL 32216
Tel: (904) 724-5767
Fax: (904) 724-5770

Records are requested for the purpose of:
(Please check one)

[ ] Continuing Medical Care [ ] Legal [ ] Insurance

[ ] Personal Use [ ] Other: ______________________________

Parts 1 and 2 must be completed to properly identify the records to be released.

1. Type of records to be released and date(s) of service (check all that apply):
[ ] Inpatient- Dates: ____________________________ [ ] Emergency Dept.- Dates: ________________
[ ] Same Day Surgery- Dates: ____________________ [ ] Outpatient Testing- Dates: _______________

2. Specific information to be released (check all that apply):

[ ] Consultation Reports	[ ] History & Physical Exam	[ ] Emergency Department Report	[ ] Rehabilitation Records
[ ] Physician Progress Notes	[ ] Laboratory Reports/Tests	[ ] Medication Administration Records	[ ] Psychiatric Psychological Evaluation
[ ] Physician Orders	[ ] Operative Report	[ ] EKG Report	[ ] Nurses Notes
[ ] Discharge Summary	[ ] Radiology Report	[ ] Pathology Report	

Other, Specify:
____

HIV and Mental Health information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.
Do not release: [ ] HIV **[ ]** Mental Health (Psychiatric)

I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information.

See side/page two of this form for additional patient rights and responsibilities.

_________________________________ _________________

Signature of Patient Date of Signature

_________________________________ _________________

Witness/Staff Member Signature Date of Signature

Please be aware that health care facilities are authorized by Florida State Law to charge for the reproduction of medical records and that charges may be associated with this request. Requester's may be notified in advance of the amount due for request and records will be sent upon receipt of payment.

Additional Patient Rights and Responsibilities

- A disclosure statement, as required by law, will accompany all records released.
- Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.
- Although applicable law may prohibit re-disclosure of these record, I understand that it is possible that the facility/person that receives the records may disclose the information, therefore (1) Omega Health & Wellness and its staff/employees have no responsibility or liability as a result of an re disclosure and (2) such information would no longer be protected by the Privacy Rule.
- My decision to revoke the Authorization does not apply to any release of my records that may have place prior to the date of my revocation of the Authorization.
- My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of the claim.
- Omega Health & Wellness cannot require me to sign the Authorization in order to receive treatment.
- In accordance with 4Pa Code 255.5 (b), Drug & Alcohol treatment information to be released to judges, probation or parole officers, insurance company, health or hospital plan government officials shall be restricted to the following: 1) Whether the client is or is not in treatment 2) The prognosis of the client 3) The nature of the program 4) A brief description of the progress of the client 5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.
- I am entitled to a copy of this completed Authorization form.

Copy of authorization must be provided to patients when authorization is initiated by Omega Health & Wellness and for all Drug and Alcohol Treatment Patients.

[ ] Copy of authorization provided to patient **[ ]** Copy of authorization refused

_____________________________________ ________________________

Signature of Patient Date of Signature

_____________________________________ ________________________

Witness/ Staff Member Signature Date of Signature

8761 Perimeter Park Blvd, Suite 101, Jacksonville, FL 32216
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