

<b>1. Patient Information</b>			
Name (First, Middle, Last)		Cleveland Clinic Indian River Hospital Medical Record # if known:	
Current Address		City	State Zip
Last 4 Digits of Social Security #	Email	Phone Number ( )	Date of Birth / /
<b>2. Release Information From</b>			
Facility/Provider:			
Address		City/State	Zip Phone Number ( )
<b>3. Release Information To:</b>			
Name of Recipient:			
Address		City/State	Zip Phone Number ( ) Fax Number ( )
Select one: Paper Secure electronic delivery (If secure delivery, provide email):			

**Purpose of Disclosure:**       **Continuity of Care**       **Other (please indicate)** \_\_\_\_\_  
(Purpose for disclosure must be completed prior to processing)

**Dates of service to release (FROM) \_\_\_\_\_ (TO): \_\_\_\_\_**

- |   |   |                                |
|---|---|--------------------------------|
| <input type="checkbox"/> Office Visits                | <input type="checkbox"/> History & Physical | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Emergency Department Reports | <input type="checkbox"/> Other _____        | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Discharge Summary            | <input type="checkbox"/> _____              | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Operative Reports            | <input type="checkbox"/> _____              | <input type="checkbox"/> _____ |

I, the undersigned, authorize the above named sending Facility/Provider as described in Section 2 to release health information as indicated/described above. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse. **This authorization does not include permission to release outpatient Psychotherapy Notes as defined below.\* Release of Psychotherapy Notes requires a separate authorization.**

**This authorization and consent will expire one year from the date of authorization written below**, unless revoked by me (or my legal representative) through written notice presented to above named Facility/Provider as described in Section 2. Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law. I understand that the sender of my health information may charge for the service of disclosing medical information and I am responsible for inquiring about these potential charges.

**If Authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Patient/Patient's Personal Representative      Printed Name      Date Signed

\_\_\_\_\_  
Relationship, if not Patient

*Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical records.*

**Submit request to one of the following:**

- |   |  |
|---|--|
| <p>(1) Health Information Management/Medical Records Department<br/> Cleveland Clinic Indian River Hospital<br/> 1000 36th Street<br/> Vero Beach, FL 32960<br/> Questions ? 772-567-4311 Ext. 1356</p> | <p>(2) Fax: 772-563-4723<br/> (3) Email: recordrelease@ccf.org</p> |
|---|--|

*NOTICE: If you send health information to Cleveland Clinic Indian River Hospital via email, please know that your message may be sent in an unencrypted email. An unencrypted email means there is a risk that the information in the email and any attachments could potentially be read by a third party when it is sent through the internet.*