

☐ Pick-up ☒ e-Delivery
☐ Mail Out ☒ CD ☐ MyChart

Authorization for Release of Confidential Medical Records

Medical Record#:

Account #:

1. Select location(s) from which records are to be released:

- ☐ Memorial Regional Hospital /
Joe DiMaggio Children's Hospital
☐ Memorial Hospital West
☐ Memorial Hospital Miramar
☐ Memorial Hospital Pembroke
☐ Memorial Home Health
☐ Memorial Manor Nursing Home

- ☐ Memorial Regional Hospital South
☐ Memorial Hospital West Cancer Center
☐ Memorial Physician Practice(s) (specify) _____
☐ Memorial Regional Hospital Cancer Center
☐ All Memorial Healthcare System Facilities
☐ Memorial Primary Clinic
☐ Other (specify) _____

2. By signing this, I authorize the above to disclose protected health information about the person named below.

Patient Name (Print): _____ Date of Birth: _____

3. Please choose the exact information to be disclosed, including dates of service, from the options below:

☐ Abstract (An Abstract Includes only the reports identified with an * OR the specific records marked below)

Date(s) of Service

- ☐ *Face Sheet _____
☐ *Discharge Summary _____
☐ *Emergency Room _____
☐ Outpatient Records _____
☐ *History & Physical _____
☐ Progress Notes _____
☐ *Operative / Procedure Reports _____
☐ Newborn ID Sheet _____

Date(s) of Service

- ☐ *Pathology Reports _____
☐ *Consultation Reports _____
☐ *EKG Reports _____
☐ *Clinical Lab Reports _____
☐ *X-ray Reports _____
☐ All Medical Records _____
☐ Other (specify) _____

Note: X-ray images must be obtained from the Radiology Department

4. This information is to be released to:

Name: Legal-Ease Digital Imaging LLC

Address: 2496 Meadowcroft Dr Burton, MI 48519

I request my records be sent to me at this e-mail address: pat.legalease@gmail.com

5. I acknowledge the following statements:

- a. I understand that I may revoke this Authorization at any time by sending a written request to the privacy officers at any facility listed on the back of this form. Such revocation will not have any effect on any action taken by Memorial Healthcare System before the revocation.
- b. This Authorization will expire six (6) months from date of signature, or when revoked or on the following date: _____
- c. I understand that this information may include information relating to: 1) Acquired Immune Deficiency Syndrome (AIDS) or Human immunodeficiency Virus (HIV) infection. 2) Mental or behavioral health or psychiatric care. 3) Treatment of drug or alcohol abuse. 4) Genetic testing results.
- d. I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the party who receives it because it may no longer be protected by the federal privacy laws.
- e. I understand that records in an electronic form can be distributed on a wide scale with relative ease and losses or unintended releases of the requested information may occur under circumstances beyond the control of MHS, its release of information vendor or the person making the request. By requesting records in this format the requestor is knowingly and voluntarily assuming this risk and all consequences, losses and damages that might result.
- f. If Memorial Healthcare System has requested this Authorization, I understand that Memorial Healthcare System will give me a copy of this Authorization form after I sign it.
- g. I understand that Memorial Healthcare System may not condition treatment, payment, enrollment or eligibility of benefits on the completion of this Authorization.
- h. This information will be used / disclosed for the following purpose(s): Litigation

This section also applies when Memorial Healthcare System requests the Authorization for marketing purposes

only. Will MHS receive compensation for this disclosure? No _____ Yes _____ If yes, compensation will be paid by _____ for disclosing information to _____

Signature of patient: _____ Phone: _____ Date: _____ Time: _____

-OR-

Signature of patient's legal personal representative: _____ Date: _____

Printed name of patient's representative: _____ Phone: _____

Relationship to patient / authority to act for patient: _____



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RECORDS**

2310-10173 (05/21)

PATIENT/LABEL

7

PAGE 1 OF 2



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7

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Authorization for Release of Confidential Medical Records

Contact Information

Attn: Release of Information/HIM Memorial Regional Hospital 3501 Johnson Street Hollywood, Florida 33021	Attn: Release of Information/HIM Joe DiMaggio Children's Hospital 3501 Johnson Street Hollywood, Florida 33021
Attn: Release of Information/HIM Memorial Regional Hospital South 3600 Washington Street Hollywood, Florida 33021	Attn: Release of Information/HIM Memorial Hospital West 703 North Flamingo Road Pembroke Pines, Florida 33028
Attn: Release of Information/HIM Memorial Hospital Miramar 1901 S.W. 172nd Avenue Miramar, Florida 33029	Attn: Release of Information/HIM Memorial Hospital Pembroke 7800 Sheridan Street Pembroke Pines, Florida 33024
Attn: Release of Information/HIM Memorial Regional Cancer Center 3501 Johnson Street Hollywood, Florida 33021	Attn: Release of Information/HIM Memorial Manor 777 S. Douglas Road Pembroke Pines, Florida 33025
Attn: Release of Information/HIM Memorial Primary Care Clinic 3501 Johnson Street Hollywood, Florida 33021	Attn: Release of Information/HIM Memorial West Cancer Center 703 North Flamingo Road Pembroke Pines, Florida 33028
Attn: Release of Information/HIM Memorial Physician Practice(s) 3501 Johnson Street Hollywood, Florida 33021	Attn: Release of Information/HIM Memorial Home Health 3501 Johnson Street Hollywood, Florida 33021

