HOSPICE of the COMFORTER (HOTC)
SPECIAL AUTHORIZATION FORM
TO OBTAIN/USE/DISCLOSE PATIENT HEALTH INFORMATION

I understand I am under no obligation to sign this form and that the person(s) and/or organization(s) described below who I am authorizing to use and/or disclose my health information may not condition treatment, payment, or enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

I authorize the following health information to be used and/or disclosed:

- ☐ Physician Orders
- ☐ Progress Notes/Serial Assessments
- ☐ History & Physical – D/C Summary
- ☐ *Psychotherapy Notes
- ☐ Verification of Patient's terminal illness
- ☐ Medication Summaries
- ☐ Labs/X-Rays
- ☐ HIV/AIDS Testing & Treatment Information
- ☐ Substance Abuse Testing & Treatment Information
- ☐ _____

*__Authorization to use or disclose psychotherapy records may not be combined with any other authorization on this form.__

I authorize the following person(s) and/or organization(s):_____
To disclose my health information to: _____

I authorize my health information to be used and/or disclosed for the following purpose(s): _____

_____

I understand that I have the right to revoke this authorization at any time. I also understand that my revocation must be in writing. To obtain a revocation form I may contact the Privacy hotline at 407-682-0808. I am aware that my revocation will not be effective if (i) this authorization was obtained as a condition for obtaining insurance and applicable law permits the insurer to contest the claim or the policy itself or (ii) to the extent the person(s) and/or organization(s) identified above have already acted in reliance upon this authorization.

I also understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses that are subject to the Federal Privacy Standards, the health information disclosed pursuant to this authorization may no longer be protected by the State and Federal Privacy Standards and such person(s) and/or organization(s) may re-disclose my health information without obtaining my authorization.

I understand that ☐ no one (or) _____ will be receiving direct or indirect remuneration in connection with the use and/or disclosure of my health information. (check "no one" (or) insert name of person(s) or organization(s) receiving such remuneration and the amount).

This authorization will be effective for one (1) year from date signed or until I revoke it.

For individuals requesting access to copy and/or inspect their PHI please check the desired method:

- ☐ I prefer to inspect and/or copy the requested information in person and will arrange for a mutually convenient time to come to Hospice of the Comforter by calling the Privacy hotline at (407) 682-0808.
- ☐ I prefer to have the requested information copied and mailed to me at the following address: _____
  _____

I understand that I will be responsible for paying a per page copying fee of $1.00 for the first 25 pages and .25 for each additional page.

- ☐ I prefer to receive a written summary of the requested information for the fee of $ _____.

_____ ____/____/____
Signature of Patient **Date**

_____
(If Patient cannot sign, explain reason)

_____ ____/____/____
Signature of Legal Representative **Date**

_____ ____/____/____
Signature/Title of HOTC Representative **Date**

Authorization of Legal Representative ☐ **HCS** ☐ **DPOA**

- ☐ **Court Appointed Guardian**
- ☐ **Legal Proxy**
- ☐ _____

Name and address of Legal Representative:

_____
_____
_____

Patient Name _____

Patient Number _____