

PATIENT'S NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

SS #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Medical Record #: \_\_\_\_\_

I hereby request and authorize **NCH Healthcare System** to release my PHI to Legal Copy Services, Inc.  
The information is to be:  Mailed To: PO Box 2845 Grand Rapids, MI 49501  
 Picked Up: \_\_\_\_\_ DATE \_\_\_\_\_ TIME \_\_\_\_\_

I understand and acknowledge that certain information which may be contained in the medical record requires specific authorization for disclosure, and except as otherwise provided by law such information may not be disclosed without my specific consent. Additionally, I have the right to refuse disclosure and prevent any other person from disclosing such information. Such information could include: (1) treatment for mental or emotional conditions, (2) alcohol/drug abuse, and/or (3) HIV testing and/or test results.

Reason for this disclosure: Civil Litigation- Pre Trial Discovery

This authorization is for the listed date(s) of treatment: From: \_\_\_\_\_ To: \_\_\_\_\_

**AN ABSTRACT OF THE MEDICAL RECORDS CONSISTS OF A DISCHARGE SUMMARY, HISTORY AND PHYSICAL, CONSULTATIONS, OPERATIVE REPORTS, X-RAYS, LABS, EKG, EMERGENCY ROOM RECORDS AND DIAGNOSTIC STUDIES.**

**Information to be released/disclosed (check all that apply):**

- |   |   |   |
|---|---|---|
| <input checked="" type="checkbox"/> <b>Abstract: including</b> , mental health information, alcohol/drug abuse, HIV testing or results. | <input type="checkbox"/> Emergency Room Record    | <input type="checkbox"/> Radiology Results  |
| <input type="checkbox"/> <b>Abstract: excluding</b> , mental health information, alcohol/drug abuse, HIV testing or results.            | <input type="checkbox"/> History and Physical     | <input type="checkbox"/> Radiology Images   |
|   | <input type="checkbox"/> Final Summary            | <input type="checkbox"/> Laboratory Results |
|   | <input type="checkbox"/> Operative/Cath Report(s) | <input type="checkbox"/> Other _____        |
|   | <input type="checkbox"/> Cardiology Images        | _____                                       |

I do hereby agree to release, indemnify and hold harmless, NCH Healthcare System, its officers, directors, employees, agents and members of its medical staff, from and against any claims against or liability incurred by it at any time, arising out of or in connection with the disclosure of medical information authorized by me pursuant to this consent. Signing this authorization may cause the health information used or disclosed pursuant to this authorization to no longer receive the protection of federal privacy laws. This consent may be revoked at any time by notifying the Privacy Officer, except to the extent that the receiving facility has already taken action in reliance on it. This consent and authorization shall automatically expire six months from the date of the consent, unless revoked by the patient or patient's authorized representative prior to that time.

I further agree to pay the fees charged to provide the information requested. The fees are waived only if the copies are forwarded to a physician office and/or healthcare provider.

Your ability to receive treatment does not depend on you signing this form, and you may refuse to sign this form. However, if the only reason you have asked us to provide health care is so that we can disclose information to a third party, we may refuse to provide the service, if you refuse to sign the form.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Representative

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

**For Department Use Only:**

Released by: \_\_\_\_\_

Date: \_\_\_\_\_

Naples Community Hospital -- 350 7<sup>th</sup> Street N., Naples, FL. 34102 (239) 436-5000  
North Collier Hospital -- 11190 Healthpark Blvd., Naples, FL. 34110 (239) 513-7000

**CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

HEALTH INFORMATION MANAGEMENT  
NCH HEALTHCARE SYSTEM, NAPLES, FL

