AUTHORIZATION FOR ACCESS TO PROTECTED HEALTH INFORMATION (PHI)
(PLEASE PRINT)

PATIENT NAME____**MR #**_________________

DATE OF BIRTH **(mm/dd/yyyy)**____________________**PHONE (w/area code)**_____________________

I hereby authorize Gulfside Hospice & Pasco Palliative Care to grant access to and request release of my medical record (PHI) in the event of my death to the following individual(s):

1. Name______________________ DOB_________Phone _______________Relation_____________
2. Name______________________ DOB_________Phone _______________Relation_____________
3. Name______________________ DOB_________Phone _______________Relation_____________
4. Name______________________ DOB_________Phone _______________Relation_____________

IMPORTANT: Please choose a verbal passcode and enter it here:

____

This code MUST be provided by your authorized individual(s) to receive access to your PHI.
Please make sure you give this verbal passcode to the individuals listed on this form.

____
Printed Name Patient or Legal Representative Relationship

____
Signature Patient or Legal Representative Date Signed

____
Printed Name Hospice Team Member Title

____
Signature Hospice Team Member Date Signed

If patient is unable to sign, state reason: ____

I understand that this authorization(s) will remain in effect until such time that I, or my lawfully acting representative, revoke any or all authorizations. To revoke this authorization(s), please call 813-501-8215.