METCARE ONCOLOGY
3200 W. GRANADA BLVD., SUITE #1
ORMOND BEACH, FL 32174
386-615-1056

METCARE AUTHORIZATION FORM

For Disclosure of Protected Health Information

This form, if signed, will authorize METCARE to disclose specified protected health information about the person(s) designated below.

1. I hereby authorize the disclosure of protected health information relating to:

Member Name: ______________________ Date of Birth: ______________

2. The person(s) who are authorized to receive this information: (Primary)

Name: RECORDS DEPOSITION SERVICE, INC. Relationship: ______________

The information disclosed is to be sent via:

☒ **Mail** Address: PO BOX 5054, SOUTHFIELD, MI 48086 - 5054
☐ **Telephone** Daytime telephone: 248.357.3330 Home telephone: ____/____-______
-OR- Cellular phone: ____/____-______
☒ **Fax** Number: 248.357.3337
☐ **Internet** (under a secure transmission) Email address: ______________
☐ **Held for pickup by:** ______________ (name of person authorized to pick up)

The person(s) who are authorized to receive this information: (Secondary)

Name: ______________ Relationship: ______________

The information disclosed is to be sent via:

☐ **Mail** Address: ______________
☐ **Telephone** Daytime telephone: ____/____-______ Home telephone: ____/____-______
Cellular phone: ____/____-______
☐ **Fax** Number: ______________
☐ **Internet** (under a secure transmission) Email address: ______________
☐ **Held for pickup by:** ______________ (name of person authorized to pick up)

3. The information to be disclosed is: ***(specify the exact information to be disclosed, including dates of service):***

☐ **Complete health record**(s) for the following date(s) of service, which may contain all the documents listed below as well as other notes/documents relating to my treatment, payment, and health operations: ______________

☐ **Specified records as indicated below:**

Document	Report	Study Date (if known)
☐	History and physical examination	______
☐	Consultation reports	______
☐	X-ray reports	______
☐	Laboratory tests	______
☐	Operative Report	______
☐	Discharge summary	______
☐	Progress notes	______
☐	Photographs, videotapes, digital or other images	______
☐	Other: ______________	______

4. I understand that the disclosed information may, unless expressly limited by me in writing, include information relating to:

Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection.
Treatment for drug or alcohol abuse.
Mental or behavioral health or psychiatric care.

5. The persons who are authorized to disclose this information are:

Personnel in the member services department at Metropolitan Health Networks, Inc. and/or personnel in the case management department who are responsible for the Disclosure of Information.

6. I acknowledge the following statements:

☐ __________ Initials: I understand that I generally may revoke this authorization at any time by notification in writing to:

METCARE of Florida, Inc.
Attn: Privacy Officer
250 South Australian Ave., Suite 400
West Palm Beach, FL 33401

of my intent to revoke this authorization, except that if I do notify METCARE in writing of my intent to revoke this authorization, such revocation will not have any affect on any actions by METCARE taken before the revocation.

☐ ________Initials: Unless otherwise revoked, this authorization will expire on:____________________
☐ ________Initials: I understand that Metcare will give me a copy of this authorization form after I sign it.

____ Date: ____/____/____
Signature of member or member's legally authorized representative
(Signers other than the member must present legal documentation that authorizes them to act on the member's behalf)

____________________________________ Date: ____/____/____
Printed name of member's representative

____
Relationship to member giving representative authority to act for member