Good Samaritan Medical Center
1309 N. Flagler Drive, West Palm Beach, FL 33401
Tel: (561) 650-6281 Fax: (561) 650-6467

ACCOUNT NO(s): ____________________
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Patient Name	Last:	First:	Middle:
Home Address		City:	State: Zip:
Home Telephone		Social Security #:	
Date of Birth		Date of Hospital Visit(s) being requested:	

Specify Information to be Disclosed:

- ☐ Face Sheet
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultations
- ☐ Operative Reports
- ☐ Radiology Reports/Mammo
- ☐ Anesthesia Records
- ☐ Pathology
- ☐ EKG/Stress Test/Holter
- ☐ Echo
- ☐ Laboratory ☐ AM Labs Only
- ☐ ER
- ☐ Orders
- ☐ Progress Notes
- ☐ Rehab (PT, OT, Speech)
- ☐ EEG
- ☐ Respiratory
- ☐ Medications
- ☐ Biopsychosocial Assessment
- ☐ Other

RECIPIENT: **Name of person(s) to whom GOOD SAMARITAN MEDICAL CENTER may disclose my health information:**

Mail to: ____ ☐ Do not mail; records will be picked up.

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TERM: **This Authorization will remain in effect:**

- ☐ From the date of this Authorization until ____________________ (Date)
- ☐ Until GSMC fulfills this request
- ☐ Until the following event occurs ____
- ☐ Until withdrawn in writing

PURPOSE: I authorize GOOD SAMARITAN MEDICAL CENTER to use or disclose my health information (**this includes the super confidential health information on the back of this form)** during the term of this Authorization for the following specific purpose(s):

- ☐ Continuity of Care
- ☐ Patient Transfer
- ☐ Personal Use
- ☐ Other

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize GOOD SAMARITAN MEDICAL CENTER to use or disclose my health information in the manner described above.

____ ____________________

Signature of Patient **Date**

If patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

____________________ ____________________ ____________________

Signature of Personal Representative **Description of Authority** **Date**

For Internal Use Only: The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the medical records.

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Signature of employee validating identity

DOB: _____/_____/_____
AdmitDate_____/_____/_____
Age ___Gender __ Race______
ACCT# ____________________ Room: ____________

PatientName:________________________________

AttendingDoctorName ____________________ MRN ______________

I understand that once GOOD SAMARITAN MEDICAL CENTER discloses my health information to the recipient, GOOD SAMARITAN MEDICAL CENTER cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that GOOD SAMARITAN MEDICAL CENTER may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at GOOD SAMARITAN MEDICAL CENTER; except, however, if my treatment at GOOD SAMARITAN MEDICAL CENTER is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case GOOD SAMARITAN MEDICAL CENTER may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to GOOD SAMARITAN MEDICAL CENTER's Privacy Office at the address listed below. The revocation will be effective immediately upon GOOD SAMARITAN MEDICAL CENTER's receipt of my written notice, except that the revocation will not have any effect on any action taken by GOOD SAMARITAN MEDICAL CENTER in reliance on this Authorization before it received my written notice of revocation.

I may contact GOOD SAMARITAN MEDICAL CENTER's Privacy Office by mail at 1309 N. Flagler Dr., West Palm Beach, FL 33401, by telephone at 561.655.5511 or by email at GSM-PrivacyOfficer@tenethealth.com.

By applying a check next to a category of super confidential information listed below and signing on the appropriate line after the checked box, I specifically authorize the use and/or disclosure of the type of super confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization:

- ☐ Mental Illness ____________________
- ☐ Developmental Disability ____________________
- ☐ Psychotherapy Notes ____________________
- ☐ HIV / AIDS Testing or Treatments (regardless of result) ____________________
- ☐ Venereal Disease ____________________
- ☐ Abuse of an Adult with a Disability ____________________
- ☐ Sexual Assault ____________________
- ☐ Child Abuse or Neglect ____________________
- ☐ Genetic Testing ____________________
- ☐ Drug/Alcohol TX ____________________
- ☐ Other

DOB: _____/_____/_____

AdmitDate_____/_____/____

Age ___Gender __ Race______

ACCT# ____________________ Room: ____________

PatientName:______________________________

AttendingDoctorName ________________ MRN ______________