CONSENT TO RELEASE PROTECTED HEALTH INFORMATION FOR TREATMENT

I (the below listed patient) hereby consent to the release of all of my protected health information (as defined by the Health Insurance Portability and Accountability Act ("HIPAA")) which includes, without limitation, mental health, genetic testing, venereal disease, tuberculosis treatment, substance abuse (e.g., drugs and alcohol), HIV/AIDS status, and diagnostic (e.g., labs and imaging) and treatment records ("PHI") for health care services I received from AdventHealth at the SDOC Center for Employee Health dated between 4/26/16 to 9/14/19 to the following:

☐ **RosenCare, LLC / Healics**

☐ **Other:** _____
(Provider name, address and fax number)

I UNDERSTAND THAT THE PHI TO BE DISCLOSED SHALL INCLUDE:

All PHI for the time period listed in the opening paragraph. (list exceptions if any): _____

_____

_____

I further understand and agree:

1. **This Consent is revocable by me, in writing (as outlined below), any time except after the action has taken place.**
2. **This Consent will only expire when I revoke this Consent.**
3. **The PHI disclosed in response to this Consent is subject to further distribution by RosenCare LLC / Healics or any other recipient that I selected above.**
4. **That I may refuse to sign this Consent.**

_____ _____
Patient Signature Patient Printed Name

_____ _____
LAP Signature LAP Printed Name
(Legally Authorized Person if patient is a minor)

_____ _____
Date of Birth of Patient Date of Signature of Consent

Send Consent to: **Email:** FH.HIM.CSC.Incoming.Faxes@AdventHealth.com **Fax**: 407-303-0633
Mailing Address: AdventHealth Orlando Health Information Management Release of Information
701 E. Altamonte Dr., Suite 2000, Altamonte Springs, FL 32701; Phone: 407-303-9175