AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

By completing and signing this form, I give permission to the Florida Department of Health to release all the records I have selected by initializing, as maintained in its Health Management System and other client data systems. The records may include information from one or more county health departments where I have received services.

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: _____ Phone #: _____

Fax #: _____

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: Florida Department of Health in St. Johns County Phone #: 904-506-6081

Fax #: 904-825-6875

Address: 200 San Sebastian View, St. Augustine, FL 32084

METHOD OF DISCLOSURE:

_____ Pick up at Clinic/Facility

_____ Mail (Address to send records): _____

_____ Fax #: _____

_____ Email Address: _____

(Please note that emailing may not be a secured method of communication)

INFORMATION TO BE DISCLOSED: (**Initial** Selection)

_____ General Medical Record(s), including STD and TB _____ Progress Notes _____ History and Physical Results

_____ Immunizations _____ Family Planning _____ Prenatal Records _____ Consultations

_____ Diagnostic Test Reports (Specify Type of test (s)) _____

_____ Other: (Specify): _____

I Specifically authorize release of information relating to: (**Initial** Section)

_____ HIV test results for non-treatment purposes _____ Substance Abuse Service Provider Client Records

_____ Psychiatric, Psychological or Psychotherapeutic notes _____ Early Intervention _____ WIC

PURPOSE OF DISCLOSURE:

_____ Continuity of Care _____ Personal Use _____ Other (specify)_____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be disclosed by the recipient and the information my not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize the treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization anytime. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

_____ _____

Client/Legal Representative Signature Date

_____ _____ _____

Client's Printed Name Date of Birth Legal Representative's Relationship to Client

If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your legal authority to request this information (for example, power of attorney, healthcare surrogate form, order or appointment of a guardianship, order appointing personal representative and letters of administration).

Original: To File Copy to Client