AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ____________________ Birth Date: ____________
Maiden/Prior Names: ____________________ Current Phone #: ____________
Current Address: ____________________ SSN#: ____________

To be released to or requested from:

☐ Self (address above)
☐ ____________ (____)____________ ____________
Agency/Organization | Telephone Number | Street Address
____________ (____)____________ ____________
Name / Attention to | Fax Number | City | State | Zip Code

Via (only when released to): ☐ Mail ☐ Fax ☐ Pick-up ☐ Email: ____________
☐ Verbal Exchange of Information ONLY

I am requesting disclosure of my protected health information for the following purpose:

☐ Continuing Care ☐ Disability Determination ☐ Child Custody ☐ Personal Use
☐ Academic ☐ Legal Investigation ☐ Billing/Insurance ☐ Other: ____________

Dates of Service Requested: ____________________

☐ **I authorize the release of the following information <u>including</u> all records that include any substance use disorder and/or substance use disorder treatment records, or**

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Only the information and records indicated below (check all that apply and /or specific if "Other is checked):

☐ Continuity/Transition of Care Packet
☐ Psychiatric Evaluation
☐ History and Physical
☐ Discharge Summary
☐ Progress Notes
☐ Physician Orders
☐ Lab/Diagnostic Reports
☐ HIV Test Results and AIDS Treatment Records
☐ Other: ____________

This authorization will expire on ____/____/20____. (If not indicated, authorization will expire <u>one year</u> from signature date)

This form must be completed in full before signing:

____________________ ____________________ ____________
Patient's signature *(under 18, must also sign by Florida Statues)* | Parent/Legal Guardian signature (if applicable) | Relationship to Patient

____________________ ____________
Witness signature/Credentials | Date Signed

This information has been disclosed to you from records protected by Federal confidentiality rules Florida Statutes 394-459, 397.501, and /or 90.503 and 42 Code of Federal Regulations (42 CFR). This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards) 45 CFR, 160 & 164, and all federal regulations and interpretative guidelines promulgated there under. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and Florida Statutes 394-459, 397.501, and /or 90.503. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
I have been informed and understand that this authorization is subject to revocation by me at any time except to the extent that Central Florida Behavioral Hospital has already taken action in reliance on it. Once the requested protected health information is disclosed, the Privacy Regulation may no longer protect it if the PHI's recipient re-discloses it. Further, I understand that despite all care taken, information is occasionally received by a party not intended to be the recipient. I hereby release Central Florida Behavioral Hospital from all liability should this information be received by someone other than the above-intended recipient.

____________________ ____________
Revocation Signature | Date/Time