



AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: _____ Phone #: _____
 Address: _____ Fax #: _____

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: Florida Department of Health Phone #: (850)245-4330
Address: 4025 Esplanade Way, Suite 130 Fax #: (850)414-6625
Tallahassee, FL 32399-1744
Other 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) Walk With Ease participant registration

I specifically authorize release of information relating to: (initial selection)

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) Chronic disease epidemiological data + grant requirements

EXPIRATION DATE: This authorization will expire (insert date or event) 6/30/2018. 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.

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

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

REVOICATION: I understand that I have the right to revoke this authorization any time. 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/Representative Signature

Date

Printed Name

Representative's Relationship to Client

Witness (optional)

Date

Client Name: _____
ID#: _____
DOB: _____