AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: Florida Department of Health in Charlotte County **Phone #:** 941-624-7200

Address: 1100 Loveland Blvd, Port Charlotte, Florida 33980 **Fax #:** 941-624-7202 **Email:** Charlotte.FrontOffice@FLHealth.gov

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: _____ **Phone #:** _____

Address: _____ **Fax #:** _____

Other method of communication (email): _____

INFORMATION TO BE DISCLOSED: Put your INITIALS in each box

____ 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) _____

X Other: (specify) 680 Form for school and Immunization History

_____

I specifically authorize release of information relating to: Put your INITIALS in each box

____ 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 of 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 re-disclosed 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.

REVOCATION: 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 or Medicare.

_____ _____

Client/Representative **Signature** Date

_____ _____

Printed Name Representative's Relationship to Client

_____ _____

Witness (optional) Date

Please complete this section (Client Name and Date of Birth)

Client Name: _____

DOB: _____