



# 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

**INFORMATION MAY BE DISCLOSED TO:**

Person/Facility: \_\_\_\_\_

Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Fax #: \_\_\_\_\_

**METHOD OF DISCLOSURE:**

\_\_\_\_\_ Pick up at Clinic/Facility

Address: \_\_\_\_\_

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.

**REDISCLASURE:** I understand that once the above information is disclosed, it may be 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 the treatment will not be denied if I refuse to sign this form.

**REVOICATION:** 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

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Legal Representative's Relationship to Client

\_\_\_\_\_  
Witness (optional)

\_\_\_\_\_  
Date

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).

Client Name: \_\_\_\_\_

ID#: \_\_\_\_\_

DOB: \_\_\_\_\_

Original: To File Copy to Client