AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: FLORIDA DEPARTMENT OF HEALTH IN MIAMI-DADE **Phone #:** (786) 845-0550

Address: 8600 NW 17TH ST SUITE 200 MIAMI, FL 33126 **Fax #:** (786) 845-0598

INFORMATION MAY BE DISCLOSED TO:

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

Address: _____ **Fax #:** _____

Other method of communication: _____

INFORMATION TO BE DISCLOSED: (Initial Selection)

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

X 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 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)_____

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 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.

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 and Medicare.

_____ _____

Client/Representative Signature Date

_____ _____

Printed Name Representative's Relationship to Client

_____ _____

Witness (optional) Date

Client Name: _____

ID#: _____

DOB: _____