AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: Alachua Clinic, Alachua County Health Department **Phone #:** 386-462-2542

Address: 15530 NW US Hwy 441, Suite 10010, Alachua, Fl 32615

INFORMATION MAY BE DISCLOSED TO:

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

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) _____STD Records _____ TB Records _____ History and Physical Results

_____ Immunizations _____ Family Planning _____ Prenatal Records _____ Consultations

_____ Progress Notes

_____ Diagnostic Test Reports (Specify Type of test(s) _____

_____ Other: (specify) _____

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

_____HIV test results _____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/Legal Representative Signature Date

_____ _____

Printed Name Legal Representative's Relationship to Client

If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your legal authority to the request this information (for example, power of attorney, healthcare surrogate form, order, appointment of a guardianship, order appointing personal representative, letters of administration).

Client Name: _____

ID#: _____

DOB: _____

Original: To File **Copy:** To Client **Copy:** To Accompany Disclosure