PATIENT INFORMATION FORM

Date of Visit _____ **Date of Birth** _____ **Sex at Birth -** **Male** ☐ **Female** ☐

Social Security Number (optional)_____ **Hispanic - Yes** ☐ **No** ☐

Legal Last Name _____ **Legal First Name** _____ **MI** ____

Preferred Name _____ **Race** (e.g., Asian/ Black/ White) _____

Home _____ **Cell** _____ **Email Address** _____

Emergency Contact Name _____ **Relationship** _____

Phone Number _____

ONLY TO BE COMPLETED IF THE PATIENT IS 17 OR UNDER AND RECEIVING PEDIATRIC OR IMMUNIZATION SERVICES

Mother First and Last Legal Name _____ **Date of Birth** _____

Father First and Last Legal Name _____ **Date of Birth** _____

Your Name _____ **Relationship to child** _____

Legal Guardian - Yes ☐ **No** ☐

Emergency Contact Name _____ **Relationship** _____ **Phone Number** _____

May we contact you via email? Yes ☐ **No** ☐ **Would you like a text message for appointment reminders? Yes** ☐ **No** ☐

Electronic communication, which includes text messaging and email, may not be a safe and secure means of communication. Some of these communications from the Department of Health may contain confidential and protected health information. I understand and acknowledge that there are risks of communicating electronically, such as, but not limited to, lack of encryption, electronic interception by others, interception by persons with access to my devices, and inadvertent transmission to the wrong number or email address. Despite such risks, by answering "yes" to receiving electronic communications, I authorize the Department of Health to communicate by electronic means. I understand that I can revoke my consent at any time by signing an updated demographic form.

Would you like to complete an Advanced Directive today? Yes ☐ **No** ☐

An advanced directive (living will) allows someone to make medical decisions on your behalf if you are unable to.

Would you like to participate in the Health Information Exchange (HIE)? Yes ☐ **No** ☐

HIE allows your medical information to be available and viewed electronically by doctors and your medical team members. It is designed to provide quick access to medical records to make treatment more effective and efficient. Any authorized healthcare provider and their team who agrees to participate in HIE can electronically access and use your protected health information, if needed, to provide treatment to you.

Please list all family members living in your home and note monthly income if applicable

(Income includes all earnings from jobs, pensions, child support, social security, death benefit, alimony, unemployment/worker's compensation, veteran benefits, investments, trust funds, rental income, self-employment, Public Assistance, grants or any other income received.)

Name	Date of Birth	Social Security Number (optional)	Relationship	Monthly Income

I affirm the information I am providing is true and correct to the best of my knowledge. I understand if I provide false or inaccurate information services may be discontinued, and I may have to pay for all services received per the appropriate fee schedule. FAC Rule 64f-10.003(5).

Signature _____ **Date**_____

REVOCATION: I understand I have the right to revoke this authorization anytime. If I revoke this authorization, I understand I must do so in writing and I must present my revocation to the medical record department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company, Medicaid and Medicare.

FORMULARIO DE INFORMACIÓN DEL PACIENTE

Fecha de visita _____ **Fecha de nacimiento** _____ **Sexo al nacer -** **Masculino** ☐ **Femenino** ☐

Número de Seguro Social (opcional)_____ **Hispano - Sí** ☐ **No** ☐

Apellido legal _____ **Primer nombre legal** _____ **Inicial del segundo nombre** _____

Nombre preferido _____ **Raza** (p. ej., asiático/negro/blanco) _____

Teléfono de casa _____ **Número de celular** _____ **Dirección de correo electrónico** _____

Nombre del contacto de emergencia _____ **Parentesco** _____

Número de teléfono _____

SOLO DEBE COMPLETARSE SI EL PACIENTE TIENE 17 AÑOS O MENOS Y RECIBE SERVICIOS PEDIÁTRICOS O DE VACUNACIÓN

Primer nombre y apellido legal de la madre _____ **Fecha de nacimiento** _____

Primer nombre y apellido legal del padre _____ **Fecha de nacimiento** _____

Su nombre _____ **Parentesco con el niño** _____

Tutor legal - Sí ☐ **No** ☐

Nombre del contacto de emergencia _____ **Parentesco** _____ **Número de teléfono** _____

¿Podemos contactarlo por correo electrónico?
Sí ☐ **No** ☐

¿Quiere un mensaje de texto para recordatorios de citas?
Sí ☐ **No** ☐

La comunicación electrónica, que incluye mensajes de texto y correo electrónico, puede no ser un medio de comunicación seguro. Algunas de estas comunicaciones del Departamento of Health pueden contener información de salud confidencial y protegida. Entiendo y reconozco que existen riesgos en la comunicación electrónica, como, entre otros, la falta de encriptación, la intercepción electrónica por parte de otros, la intercepción por personas con acceso a mis dispositivos y la transmisión accidental a un número o correo electrónico equivocado. A pesar de estos riesgos, si respondo "sí" para recibir comunicaciones electrónicas, autorizo al Departamento de Salud a comunicarse por medios electrónicos. Entiendo que puedo revocar mi consentimiento en cualquier momento si firmo un formulario demográfico actualizado.

¿Quiere completar una directiva anticipada hoy? Sí ☐ **No** ☐

Una directiva anticipada (testamento vital) permite que alguien tome decisiones médicas en su nombre si usted no puede hacerlo.

¿Quiere participar en el Intercambio de Información de Salud (HIE)? Sí ☐ **No** ☐

El HIE permite que su información médica esté disponible y sea vista electrónicamente por médicos y miembros de su equipo médico. Está diseñado para dar acceso rápido a los registros médicos para hacer que el tratamiento sea más efectivo y eficiente. Cualquier proveedor de atención médica autorizado y su equipo que acepte participar en el HIE puede acceder electrónicamente y usar su información de salud protegida, si es necesario, para darle tratamiento.

Enumere a todos los miembros de la familia que viven en su vivienda e indique el ingreso mensual si corresponde

(El ingreso incluye todas las ganancias de trabajos, pensiones, manutención infantil, Seguro Social, beneficios por fallecimiento, pensión alimenticia, compensación por desempleo/para trabajadores, beneficios para veteranos, inversiones, fondos fiduciarios, ingresos por alquiler, trabajo por cuenta propia, Asistencia Pública, subsidios o cualquier otro ingreso recibido).

Nombre	Fecha de nacimiento	Número de Seguro Social (opcional)	Parentesco	Ingreso mensual

Afirmo que la información que doy es verdadera y correcta según mi leal saber y entender. Entiendo que, si doy información falsa o inexacta, los servicios pueden suspenderse y es posible que tenga que pagar por todos los servicios recibidos según la lista de tarifas correspondiente.
Regla del FAC 64f-10.003(5).

Firma _____ **Fecha**_____

REVOCACIÓN: Entiendo que tengo derecho a revocar esta autorización en cualquier momento. Si revoco esta autorización, entiendo que debo hacerlo por escrito y debo presentar mi revocación al departamento de registros médicos. Entiendo que la revocación no se aplicará a la información que ya se haya revelado en respuesta a esta autorización. Entiendo que la revocación no se aplicará a mi compañía de seguros, Medicaid y Medicare.

Florida HEALTH

Alachua County Health Department

CLIENT'S BILL OF RIGHTS

1. **Clients have the right to healthcare that is accessible and meets professional standards.**
2. **Clients have the right to courteous and individualized healthcare that is equitable, humane, and given without discrimination as to race, color, creed, sex, gender identity, gender expression, sexual orientation, national origin, source of payment, or ethical or political beliefs.**
3. **Clients have the right to information about their diagnosis, prognosis, and treatment – including alternatives to care and risks involved – in terms they and their families can readily understand, so that they can give their informed consent.**
4. **Clients have the legal right to informed participation in all decisions concerning their healthcare and the right to refuse treatment, to the extent permitted by law, and to be informed of the medical consequences of their actions.**
5. **Clients have the right to information about the qualifications, names, and titles of personnel responsible for providing their healthcare.**
6. **Clients have the right to refuse observation by those not directly involved in their care.**
7. **Clients have the right to privacy during interview, examination, and treatment.**
8. **Clients have the right to privacy in communicating and visiting with staff.**
9. **Clients have the right to refuse treatments, medication, or participation in research and experimentation, without punitive action being taken against them.**
10. **Clients have the right to coordination and continuity of healthcare.**
11. **Clients have the right to appropriate instruction or education from healthcare personnel so that they can achieve an optimal level of wellness and an understanding of their basic health needs.**
12. **Clients have the right to confidentiality of all records (except as otherwise provided for by law or third-party payer contracts) and all communication, written or oral, between clients and healthcare providers.**
13. **Clients have the right to examine and receive an explanation of his/her bill regardless of source of payment.**
14. **The client has the right to know what rules and regulations apply to his conduct as a client.**

Client Signature: _____ **Date:** _____

Witness: _____

ACHD Revised 9/18/2026

Place Label Here

ALACHUA COUNTY HEALTH DEPARTMENT CLIENT RESPONSIBLITIES

1. You are responsible for treating all staff and other clients with respect and consideration.
2. You are responsible for answering all questions regarding program eligibility and medical history, etc., completely and correctly to the best of your knowledge.
3. You are responsible for keeping your appointments and obtaining the phone number to call in advance if you have to cancel the appointment.
4. You are responsible for paying all bills when service is provided, unless other arrangements have been made.
5. You are responsible for obeying rules and regulations as posted by the Health Unit or explained by the staff. Some of these rules are:
    A. Monitor and control the behavior of your children while at the clinic.
    B. No food or drink allowed in clinic.
    C. Dispose of garbage in appropriate containers.
6. If you have Medicaid, you must bring your Medicaid card with you to clinic appointments.
7. If you are referred for special care, emergency room, or for hospitalization for a higher level of care, you will be responsible for payment of any services such rendered.

I understand if I miss more than three (3) scheduled medical appointments in a six-month period or do not provide 24 hour notice of cancellation of an appointment more than three (3) times in a six month period, I may be disenrolled from primary care medical services provided by the Alachua County Health Department.

I understand if I miss more than two (2) scheduled DENTAL medical appointments in a six-month period or do not provide 24 hour notice of cancellation of an appointment more than two (2) times in a six month period, I may lose routine dental care services for six (6) months, though emergency services will still be provided.

I understand that either the Health Care Program I am enrolled in or my Health Insurance Carrier may require me or my child to have a Physical Exam yearly if we receive primary care services. If I decline these services or fail to fulfill this requirement for myself or my child, I understand I may be disenrolled from primary care medical services provided by the Alachua County Health Department.

I understand if I am disruptive or treat clients or staff of the Alachua County Health Department without respect and consideration, I may be disenrolled from primary care medical services provided by the Alachua County Health Department.

I understand if I do not receive medical services from the Alachua County Health Department for a period greater than fifteen (15) months, I may be disenrolled from primary care medical services provided by the Alachua County Health Department.

I understand if I have an insurance coverage change or my insurance lapses, I may be disenrolled from primary care medical services provided by the Alachua County Health Department.

I understand if the Alachua County Health Department has a change in primary care funding, I may be disenrolled from primary care medical services provided by the Alachua County Health Department.

I understand I have the right to appeal a disenrollment decision within thirty (30) days of receiving a 'Termination of Services' notice from the Alachua County Health Department. I must send a written request to have my case reviewed to:

Alachua County Health Department
Attention: Administrator
224 SE 24th Street
Gainesville, Florida 32641

I understand I have the right to file a grievance within thirty (30) days of the date the grievance occurred. I must send a written request to have my grievance reviewed to:

Alachua County Health Department
Attention: Administrator
224 SE 24th Street
Gainesville, Florida 32641

Client Signature: _____ Date: _____

Witness: _____ Date: _____

ACHD Revised 9/18/2026

Place Label Here

INITIATION OF SERVICES

PART I **CLIENT-PROVIDER RELATIONSHIP CONSENT**

Client Name: _____

Name of Agency: Alachua County Health Department

Agency Address: 224 SE 24th Street, Gainesville, FL 32641

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical visits including obtaining medical history, assessment, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.

_____By initialing this line, I acknowledge that I have been provided with a Telehealth Informed Consent Informational Sheet and that I consent to the provision of some services to be provided by means of telehealth. I may withdraw my consent at any time by discontinuing the use of telehealth services without affecting my right to future care or treatment.

PART II **DISCLOSURE OF INFORMATION CONSENT** (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my health information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, social and behavioral determinates of health, and case management; for treatment, payment and health care operations. Additionally, I consent to my health information being shared in the Health Information Exchange (HIE), allowing access by participating doctors' offices, hospitals, care coordinators, labs, radiology centers, and other health care providers through secure, electronic means. If you choose not to share your information in the HIE, you may opt out by requesting and signing an HIE Opt - Out form.

PART III **MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST** (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my health information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above-named agency and authorize it to submit a claim to Medicare for payment.

PART IV **ASSIGNMENT OF BENEFITS** (Only applies to Third Party Payers)

As Client/Representative signed below, I assign to the above-named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V **COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER**

(This notice is provided pursuant to Section 119.071(5)(a), Florida Statutes.)

For health care programs, the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071(5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

PART VI **MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS**

_____ _____ _____

Client/Representative Signature | Self or Representative's Relationship to Client | Date

_____ _____

Witness (optional) | Date

PART VII **WITHDRAWAL OF CONSENT**

I,_____WITHDRAW THIS CONSENT, effective _____

Client/Representative Signature | Date

For Office Use Only – Print or Use Label

Client Name: _____

MRN: _____

DOB: _____

Original to file; Copy to client

DH 3204-SSG-03/2025

MEDICAL AND DENTAL HISTORY

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Is the patient under a physician's care now?	◯ Yes ◯ No	If yes
Has the patient ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Has the patient ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Is the patient taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Is the patient on a special diet?	◯ Yes ◯ No	
Does the patient use tobacco?	◯ Yes ◯ No	
Does the patient use controlled substances?	◯ Yes ◯ No	If yes

Female patients: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Is the patient allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Health History

Does the patient currently have, or have had in the past, any of the following?

PLEASE CHECK EVERY BOX INDIVIDUALLY, NO LINES THROUGH

Hemophilia/Blood Disorder	◯ Yes ◯ No	Radiation or Chemotherapy	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No
Hepatitis A	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No
Hepatitis B or C	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Herpes	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Epilepsy/Seizures/Convulsions	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives/Rash/Eczema	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Cancer	◯ Yes ◯ No
Lung Disease	◯ Yes ◯ No	Thyroid or Parathyroid Disease	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No
Mitral Valve Prolapse	◯ Yes ◯ No	Chronic Tonsil/Adenoids Infections	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No
Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Conditions	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No
Venereal Disease	◯ Yes ◯ No	ADD/ADHD	◯ Yes ◯ No	Autism Spectrum Disorder	◯ Yes ◯ No
Sleep Apnea/Snoring	◯ Yes ◯ No	Mouth Breathing/Excessive Gagging	◯ Yes ◯ No	Anxiety/Depression	◯ Yes ◯ No
AIDS/HIV	◯ Yes ◯ No				

Have the patient ever had any serious illness not listed above? ◯ Yes ◯ No If yes

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE PROVIDE DETAILS HERE:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

A Patient's Guide to Understanding Health Information Exchange

What is Health Information Exchange and why is it important?

Health Information Exchange, or HIE, is a way of instantly sharing health information among doctors' offices, hospitals, labs, radiology centers, and other healthcare organizations. HIE allows delivery of the right health information to the right place at the right time, providing safer, more timely, efficient, patient-centered care.

The exchange of patient information is protected through strict medical privacy and confidentiality procedures. HIE improves the speed, quality, safety, and cost of patient care.

What are the benefits of having an HIE?

Gathering health information on a patient can take hours or even weeks, and sometimes the information is not available at all. Errors are common. Through the HIE, providers have immediate access to important information. The HIE helps to avoid unneeded tests and procedures, medical mistakes, and costly medical bills.

How is my medical information kept private?

Protecting patient information in the FDOH HIE is a priority. The Florida Department of Health (FDOH) follows all state and federal privacy and security laws to protect patient health information. The Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security, and Breach Notification Rules are the main Federal laws that protect your health information.

While there are many benefits to participating in the HIE, exchanging information electronically also has risk. Potential risks include errors in clinical data, reach of information, and inappropriate use. FDOH is confident that many of these risks are mitigated by protections and security process that are in place.

How is the patient's consent to participate in the HIE documented at the County Health Department?

To receive services from the CHD, patients are required to sign the Department's Initiation of Services (IOS) form. The IOS captures the consent to disclose this information. The form states "I consent to the use and disclosure of my health information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations." Clinics may ask their clients to sign an IOS annually, but this can be determined by each CHD.

Can a patient choose not to participate in the HIE?

Yes, patients can choose to opt out of the FDOH HIE. As part of receiving care in the State of Florida, your health information is available through the HIE to doctors for the purposes of treatment, unless you choose to opt out. Choosing to opt out generally means that providers cannot access any of your health information through HIE. In accordance with the law, public health reporting, such as the reporting of infectious diseases to public health officials, still occurs through the HIE after you decided to opt Out.

For more information about the Patient Privacy Policy for the Florida Department of Health please visit www.floridahealth.gov/privacy-policy.html.

HEALTH INFORMATION EXCHANGE (HIE) OPT-OUT FORM

The Health Information Exchange (HIE) allows your medical information to be available and viewed electronically by doctors and your medical team members. The HIE is designed to provide quick access to medical records to make treatment more effective and efficient. Any authorized healthcare provider and their medical team who agree to participate in the HIE can electronically access and use your protected health information, if needed, to provide treatment to you.

Patient Information		
Last Name	First Name	Middle Name
Previous Name or Nickname	Date of Birth	Primary Phone Number
Address	City	State ZIP Code

I and/or my legally authorized representative have considered whether to allow my information to be viewed in the HIEs in which the Department of Health participates and have decided to ***OPT-OUT*** *and* ***NOT*** *allow information to be viewed in the HIEs in which the DOH participates.* A decision to complete the form will not have any effect on any benefits to which you may otherwise be entitled, however, you will not be able to participate in HIE.

By choosing to opt out of the HIEs, I hereby acknowledge and agree as follows:

» This revocation only applies to the sharing of health information through the HIE. Health care providers may still have access to my health information using other methods such as fax, telephone, or mail.

» By opting out of participation in the HIE, my healthcare providers outside of DOH will NOT be able to search for my DOH records through the HIE while providing me treatment.

» My HIE OPT-OUT election will remain in effect until I notify DOH, and sign a Revocation of HIE Opt-Out Request Form.

» This HIE OPT-OUT request may take up to seven (7) business days to take effect.

» Any information that is shared before I submit this HIE OPT-OUT form may remain with providers who accessed this information before this OPT-OUT went into effect.

If this form is signed by someone other than the person named above, the person signing this form certifies that they are acting as (check one) _____Parent, _____Legal Guardian, or _____ Healthcare Power of Attorney for the person named above.

Printed Name: _____ Signature: _____

Date: _____

Living Will

Declaration made this _____ day of _____, 2____, I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and

_____(initial) I have a terminal condition,
or _____(initial) I have an end-stage condition,
or _____(initial) I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I do ___, I do not ___ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name _____
Street Address _____
City _____ State _____ Phone _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional): _____
_____
_____
_____
_____

(Signed) _____

Witness _____
Street Address _____
City _____ State _____
Phone _____

Witness _____
Street Address _____
City _____ State _____
Phone _____

At least one witness must not be a husband or wife or a blood relative of the principal.

4

Your health information is transmitted securely and only authorized health care providers with a valid reason may access your information. By sharing information electronically through a secure system, the risk that your paper of faxed records may be misused or misplaced is reduced.

Participation in HIE is completely your choice.
Choice 1. YES to HIE participation. If you agree to have your medical information shared through HIE and you have a current Initiation of Services form on file, you need not do anything, By signing that form, you have granted the Department permission to share your health information through the HIE.

Choice 2. NO to HIE participation. You can choose to not have your information shared electronically through the HIE network (opt out) at any time, by completing the Health Information Exchange Opt-Out Form available at the county health department. If you decide to opt out of HIE, health care providers will not be able to access your health information through HIE. You should understand that if you opt out, the health care providers treating you are still permitted to contact the Department to ask that your health information be shared with them as stated in this Notice of Privacy Practices. Opting out does not prevent information from being shared between members of your care team. Please note, opting out does not affect health information that was disclosed through HIE prior to the time you opted out.

Choice 3. You may change your mind at any time. You may consent today to the sharing of your information via HIE and change your mind later by following the instructions on the opt out form described under Choice 2. Alternatively, you may opt out of HIE today and change your mind later by submitting the Department's Revocation of HIE Opt Out Request Form.

PERSONAL HEALTH RECORDS (PHR) MOBILE APPLICATION SYNCHRONIZATION WITH USER DATA
As part of the services provided by the Department, you can download the companion PHR mobile application to access your personal health records. This application is the mobile version of the Florida Health Connect portal.
The purpose of the PHR mobile application is to provide you with access to your health information through your mobile device. You can synchronize your Florida Health Connect account through the mobile application with your personal health information captured on your mobile device (Google Fit or Apple Health) to provide you with a 360 degree view of your health history and current health status. Your Google Fit or Apple Health information will not be disclosed to any third parties without your express written permission.

DEPARTMENT OF HEALTH DUTIES
The Department is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the Department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. The Department has the responsibility to notify you following a breach of your unsecured protected health information. As part of the Department's legal duties, this Notice of Privacy Practices must be given to you.

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The Department is required to follow the terms of the Notice of Privacy Practices currently in effect.
The Department may change the terms of its notice. The change, if made, will be effective for all protected health information maintained by the Department. New or revised Notices of Privacy Practices and all forms referenced in this Notice of Privacy Practices may be accessed on the Department's website at https://www.floridahealth.gov/about/ patient-rights-and-safety/hipaa/index.html and will be available by email and at all Department of Health locations. Also available are additional documents that further explain your rights to inspect, copy, or amend your protected health information.

COMPLAINTS
If you believe your privacy health rights have been violated, you may file a complaint with the: Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775.

The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Department will not retaliate against you for filing a complaint.

FOR FURTHER INFORMATION
Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245- 4141.

EFFECTIVE DATE
This Notice of Privacy Practices is effective beginning February 25, 2025, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

REFERENCES
"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. Federal Register 65, no. 250 (December 28, 2000).
"Standards for the Privacy of Individually Identifiable Health Information; Final Rule" 45 CFR Part 160 through 164. Federal Register, Volume 67 (August 14, 2002).
HHS, Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information and Nondiscrimination Act; Other Modifications to the HIPAA Rules, 78 Fed. Reg. 5566 (Jan. 25, 2013).
45 CFR Parts 160 and 164 RIN 0945-AA20, April 26, 2024).

Florida HEALTH

DH8000-SSG-03/2025

Florida HEALTH

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY

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USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Protected health information includes demographic, social and behavioral determinants of health (SBDOH), and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, Social Security number and any other means of identifying you as a specific person. SBDOH may include, but not be limited to, income, food insecurity, socioeconomic status, education level, homeless. Protected health information contains specific information that identifies a person or can be used to identify a person. Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Department of Health (Department) can act as each of the above business types. This medical information is used by the Department in many ways while performing normal business activities.

Your protected health information may be used or disclosed by the Department for purposes of treatment, payment, and health care operations. Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department may use or disclose your health information for case management and services. The Department clinic or hospital may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided to you.

Your information may be used by certain Department personnel to improve the Department's health care operations. The Department also may send you appointment reminders, information about treatment options or other health-related benefits and services. Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Internal investigations and audits by the Department's divisions, bureaus, and offices.
- Investigations and audits by the state's Inspector General and Auditor General, and the Florida Legislature's Office of Program Policy Analysis and Government Accountability.
- Public health purposes, including vital statistics, disease reporting, public health surveillance, investigations, interventions, and regulation of health professionals*.
- District medical examiner investigations*.
- Research approved by the Department.
- Court orders, warrants, or subpoenas*.
- Law enforcement purposes, administrative investigations, and judicial and administrative proceedings*.

*A disclosure of reproductive health records by the Department to law enforcement, a judicial or administrative tribunal, medical examiner, or health oversight entity will require an attestation by the requesting individual or entity before such records are released by the Department. The attestation requires acknowledgment of one of the following provisions:

- The purpose of the use or disclosure of protected health information is not to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to identify any person for such

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- The purpose of the use or disclosure of protected health information is to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, or to identify any person for such purposes, but the reproductive health care at issue was not lawful under the circumstances in which it was provided.

Other uses and disclosures of your protected health information by the Department will require your written authorization. These uses and disclosures may be for marketing or research purposes, certain uses and disclosure of psychotherapist notes, and the sale of protected health information resulting in compensation to the Department. This authorization will have an expiration date that can be revoked by you in writing.

INDIVIDUAL RIGHTS

You have the right to request the Department to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The Department is not required to agree to any restriction.

You have the right to be assured that your information will be kept confidential. The Department will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where the Department may contact you.

You have the right to inspect and receive a copy of your protected health information that is maintained by the Department within 30 days of the Department's receipt of your request to obtain a copy of your protected health information. You must complete the Department's Authorization to Disclose Confidential Information form and submit the request to the local county health department or Children's Medical Services office. If there are delays in the Department's ability to provide the information to you within 30 days, you will be told the reason for the delay and the anticipated date your request can be fulfilled.

Your inspection of information will be supervised at an appointed time and place. You may be denied access to some records as specified by federal or state law. If you choose to receive a copy of your protected health information, you have the right to receive the information in the form or format you request. If the Department cannot produce it in that form or format, you will be given the information in a readable hard copy form or another form or format that you and the Department agree to.

The Department cannot give you access to psychotherapy notes or certain information being used in a legal proceeding. Records are maintained for specified periods of time in accordance with the law. If your request covers information beyond that time, the Department is not required to keep the record and the information may no longer be available. If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the Department.

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You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. The Department of Health may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the Department.
- Is not protected health information.
- Is, by law, not available for your inspection.
- Is accurate and complete.

If your correction is accepted, the Department will make the correction and inform you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The Department may respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures the Department may have made of your protected health information. This summary does not include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures to health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled persons.
- Disclosures prior to April 14, 2003.

This summary does include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6 year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request. The Department of Health may mail, text, or call you with health care appointment reminders.

PARTICIPATION IN THE HEALTH INFORMATION EXCHANGE NETWORK

Access to information about your health history, societal and behavorial factors, and medical care is critical to help ensure that you receive high-quality care and gives your health care provider a more complete picture of your overall health. This can help your provider make informed decisions about your care. Recent advancements in technology now support the safe and secure electronic exchange of important clinical information from one health care provider to another through Health Information Exchange (HIE) networks. The Department and its county health departments participate in an HIE network and also participate in several HIE networks with trusted outside health care providers to quickly and securely share your health information electronically among a network of health care providers, including physicians, hospitals, laboratories and pharmacies.