AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: _____ Phone #: _____

Address: _____

INFORMATION MAY BE DISCLOSED TO:
Person/Facility: **UNION COUNTY HEALTH DEPARTMENT-NEW RIVER HEALTH** Phone #: **386-496-3211**
495 E MAIN STREET, LAKE BUTLER, FL 32054 Phone #: **386-496-1599**

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 _____TB _____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** 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.
REDISCLOSURE: I understand that once the above information is disclosed, it may be disclosed by the recipient and the information my 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.
REVOCATION: 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: _____