Authorization—Release

Hillsborough County

Authorization for Release of Super-Confidential or Protected Health Information (PHI)

Directions: This form is to be used to obtain an individual's authorization for the disclosure of his or her super-confidential or protected health information. Its contents should be entered into the HIPAA compliance system by your Privacy Liaison. The form should also be filed with the patient's records.

Patient's/Individual's Name: ____ **Birth Date:** __________________

Social Security No.: ___________________ **Address:** ____

Telephone: _________________ **City/State/ZIP:** ____

Certain records are privileged and confidential and a general medical authorization to release psychiatric and/or psychological, HIV, and drug/alcohol treatment information is invalid according to State and/or Federal laws. These records cannot be released without this specific authorization except in the event of a valid emergency, upon receipt of a court order, or under receipt of a request authorized by law.

I hereby authorize ____________________ (Department) to release of my entire medical records to ___________________ (Physician/Agency) as specified below:

INITIAL EACH THAT APPLIES:

______ Initial — Psychiatric/Psychological Records (Evaluation, assessment, treatment attendance and discharge plan)

______ Initial — Alcohol and/or Drug Abuse Treatment Records (Assessment, treatment plan, attendance plan, discharge plan)

______ Initial — Neurological Evaluation

______ Initial — Hearing Evaluation

______ Initial — Social/Developmental History

______ Initial — Psychotherapy Notes

______ Initial — Individual Education Support Plan/Family

______ Initial — HIV/AIDS Records

______ Initial — Medical Records

______ Initial — Rehabilitation Plan

______ Initial — Speech/Language Evaluation

______ Other (Be specific): ____

PURPOSE OR NEED FOR INFORMATION:

I have given my consent freely, voluntarily and without coercion. All information received as a result of this Authorization is protected under federal and state laws and cannot be re-disclosed without my further written permission except in compliance with these laws.

This Authorization will expire upon satisfaction of the need for disclosure, not to exceed five years after the date signed. I may revoke this Authorization at any time providing I notify the Department of Health and Social Services in writing to that effect. However, such revocation will have no effect on any action previously taken.

Original Signature of Client: ____ Date: _______________________

Original Signature of Guardian/Personal Representative (If Applicable): ____________________________________

Relationship: ____ Date: _______________________

Original Signature of Witness or Notary: _____________________________ Date: _______________________

Proof of Identification: ______________________

For internal use only:
Date Received: _________________
Recipient: _____________________