



**Disclosure Authorization
Authorization for
Use or Disclosure of
Protected Health Information (PHI)
Held by Hillsborough County**

Directions: This form is to be used to obtain an individual's authorization for the disclosure of his or her 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.

Read this page carefully and sign the disclosure authorization to confirm that you understand its content.

Federal law says that we cannot share an individual's health information without the individual's permission except in certain situations. By signing this form, you are giving us permission to share the information you indicate below to a third party. This form must be completed and signed by you or by an individual who has the authority to act on your behalf (parent of a minor, legal guardian, trustee, power of attorney, personal representative).

Patient/client's full name: _____

Date of birth: _____

SSN or other patient identifier: _____

Phone number: _____ Fax number: _____

I give permission to Hillsborough County and its contract representatives to share the health information listed below with (name and address of those you are authorizing Hillsborough County to disclose your information to):

Indicate the specific *information* that you want to be disclosed, including the County Department name, and the *time period* that the information covers:

Information to be disclosed: _____

Date range: _____

Purpose of information (may state "at the request of the individual"):

Enter the date you want this authorization to expire (If you do not enter a date, this authorization will expire in one year): _____



I understand that the information described above may be re-disclosed by the recipient of the information, and that my information would no longer be protected by the federal privacy regulations. Therefore, I release Hillsborough County, its workforce members and its contract representatives from any and all liability arising from the disclosure of my health information pursuant to this authorization.

I understand that I may revoke this authorization by notifying the County through its compliance officer or department privacy liaison (and security liaison for any incidents involving ePHI), in writing, knowing that previously disclosed information would not be subject to my revocation request. I understand that exceptions exist to my right to revoke this authorization. Those exceptions include disclosures requested by the Secretary of the Department of Health and Human Services, for use in a facility directory, to provide emergency treatment, or as required by 45 CFR § 164.512, which includes uses and disclosures required and allowed in connection with treatment, payment and operation; in connection with public health activities; about victims of abuse, neglect or domestic violence; for health oversight activities; for judicial and administrative proceedings; for law enforcement purposes; about decedents; for organ donation; for research purposes; to avert serious threat to health or safety; for specialized government functions; and for workers' compensation.

Original signature of individual
or individual's Personal Representative _____

Print name: _____

Date: _____

Type of photo identification of individual or individual's representative: _____
(Attach photocopy)

If you are not the individual but represent the individual, please attach a copy of the legal document that verifies that you are a representative (parent of a minor, legal guardian, trustee, power of attorney, personal representative of the estate).

Original signature of Hillsborough
County staff receiving this authorization _____

<p><i>For internal use only:</i> Date Received: _____ Recipient: _____</p>
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