



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's/Individual's Name: _____ Birth Date: _____

Address: _____

Telephone: _____ City/State/ZIP: _____

I hereby authorize _____ (Department) to release my/ _____ (Name) entire medical records to _____ (Physician/Agency) as specified below:

INITIAL EACH THAT APPLIES:

Table with 6 columns: Initial, Neurological Evaluation, Initial, Hearing Evaluation, Initial, Social/Developmental History. Rows include Psychotherapy Notes, Medical Records, Psychiatric/Psychological Records, and Alcohol and/or Drug Abuse Treatment Records.

_____ Other (Be specific): _____

I understand that Hillsborough County is committed to protecting my personal health information under the HIPAA Privacy and Security Rules 45 C.F.R. §§ 164.103, 164.105.

I understand that I may select which information may be released by placing my initials in the area provided. PHI is confidential and protected by federal regulations, which prohibit further disclosure without specific written authorization from me or as otherwise permitted by federal and state law.

I understand that this Authorization may be revoked upon written notice to the health care provider except to the extent that action has already been taken in reliance on this Authorization. This Authorization may be revoked by writing or faxing the County and specifying the date this Authorization was signed. This Authorization will expire one year from today's date unless an expiration date or event is indicated. Expiration date/event: _____

Patient/Parent/Legal Representative (Signature in Full)* Patient's DOB Date of Authorization

Translator/Interpreter, if any (Print Name, Address, and Phone Number)

Type of Identification Presented

Expiration Date

For internal use only:
Date Received: _____
Recipient: _____