



**Hillsborough
County Florida**

Patient Authorization

Hillsborough County Patient Authorization to Use and Disclose Protected Health Information

Patient Name: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Date of Birth: _____

By signing this Authorization, I hereby direct the use or disclosure by Hillsborough County _____ Department of certain protected health information (PHI) pertaining to the patient listed above. This Authorization concerns the following information about the patient:

This information may be used or disclosed by Hillsborough County _____ Department and may be disclosed to:

I understand that I have the right to revoke this Authorization at any time, except to the extent that Hillsborough County _____ Department has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to Hillsborough County _____ Department's HIPAA Liaison:

_____ Tampa, FL 33601

_____@hillsboroughcounty.org

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to privacy protections provided by law.

I understand that my written authorization is not required for Hillsborough County _____ Department to use my protected health information for treatment, payment and healthcare operations.



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I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorization. The Authorization is being requested by Hillsborough County _____ Department for the following purpose(s):

The use or disclosure of the requested information will ___/will not ___ result in direct or indirect remuneration to Hillsborough County _____ Department from a third party.

I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms.

This authorization expires on: _____ (date or event).

Signature: _____ **Date:** _____

Personal Representative Information (if signer is different from patient):

Name: _____

Relationship to Patient (parent, legal guardian, etc.): _____

Description of the authority of personal representative:

Street Address: _____

City: _____ State: _____ Zip Code: _____