Hillsborough County Florida

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:

_____ 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
_____ 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)		

_____ 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: _____

Post Office Box 1110
Tampa, Florida 33601