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:

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

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____

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.

Hillsborough County Florida

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):

____

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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: _________________