UNIVERSITY OF FLORIDA
Privacy of Health Information

AUTHORIZATION to Use or Disclose Protected Health Information

Patient Name	Date of Birth	Medical Record Number
Verification of Identity (Driver's License, ID Card, Passport,etc.)		Social Security Number

** Complete the following only if the person authorizing the use or disclosure is not the patient:

Name	Relationship to Patient	Legal Authority
Verification of Identity	Verification of Authority	

By signing this form, I authorize: _____
Person, class of persons, or organization

To disclose to: _____ Attn: _____
Person, class of persons, or organization

Address _____ Phone _____

The following protected health information: _____

I further authorize the disclosure of information related to: (*Check all that are approved*.)
[ ] Mental Health [ ] Substance Abuse [ ] HIV/AIDS, which may be included in the protected health information listed above.

The purpose of the use or disclosure is: _____

I understand that, by federal law, the University of Florida may not use or disclose my health information, except as provided in the University's Notice of Privacy Practices, without my authorization. My signature on this Authorization indicates that I am giving permission for the uses and disclosures of the protected health information described above. I hereby release Shands at the University of Florida and its employees from any and all liability that may arise from the release of the information as I have directed.

I understand that I have the right to revoke this Authorization at any time. If I want to revoke this authorization, I must do so in writing, and address it to the person or institution named above that I am authorizing to disclose my information. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization.

I understand that I may refuse to sign this Authorization. I also understand that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this Authorization.

I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

I understand that I may be charged a fee of up $1.00 per page (plus applicable tax and handling) for every page copied. This fee is waived for copies provided to a health care provider for continuing medical care. I understand that this fee is within the limits allowable by Florida law.

This authorization expires automatically upon _____
Date or Event

I have read and understand the information in this authorization form.

Signature of Patient or Legal Representative: _____

Please print name: _____ Date: _____