Authorization for the Use and Disclosure of Protected Health Information

Information Identifying the Individual Whose Records Are Being Requested

Name of Individual: _____ SSN: _____

Disclosure of your Social Security Number is not mandatory. The Agency for Health Care Administration may request your Social Security Number pursuant to Section 119.071, Florida Statutes. If provided, the Agency will use your information for purposes of finding the requested information.

Medicaid ID or Gold Care Number: _____

Phone Number: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Specific records requested including date range:

_____

_____

Person(s), group or entity these records are being released to:

_____

Purpose for this disclosure: _____

Date I wish this authorization to expire (expires in one year if no date is provided): _____

___ I Do ___ I Do Not include specific authorization to include documents related to sensitive health conditions including: drug, alcohol or substance abuse, psychological or psychiatric treatment, sickle cell anemia, birth control or family planning, genetic diseases or tests, tuberculosis, HIV/AIDS or sexually transmitted diseases.

I understand the following: I have the right to revoke this authorization at any time by writing to the Agency's Privacy Officer or completing the revocation section on the second page of this form and sending it to the address listed for the Agency's Privacy Officer. The information described above may be re-disclosed by the person or group that I am giving the Agency permission to disclose to and therefore my information may no longer be protected by Federal privacy regulations. I may inspect or request copies of any information disclosed by this authorization if the Agency initiated this request for disclosure. I may revoke this authorization by notifying the Agency in writing with the understanding that previously disclosed information would not be subject to my revocation request. I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment, payment for health care services or eligibility for benefits.

I DECLARE UNDER PENALTY OF LAW THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

Signature: _____ Date: _____

Printed Name: _____

Legal Authority (If Other Than Individual): _____

If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your legal authority to request this information (for example, power of attorney, guardianship papers, health care surrogate form, Custody Order, Order Appointing Personal Representative, Letters of Administration).

Authorization for the Use and Disclosure of Protected Health Information

Instructions for Completing the Authorization for the Use and Disclosure of Protected Health Information Form

1. Complete the first page of this form and return it to: **HIPAA Privacy Officer, Agency for Health Care Administration, 2727 Mahan Dr., MS #4, Tallahassee, FL 32308, Phone: 850-412-3960, Fax (850) 414-6837, Email HIPAAComplianceOffice@AHCA.MyFlorida.com**.

2. Special types of health information have specific laws and rules that must be followed before that information may be disclosed:

HIV/AIDS and Sexually Transmitted Diseases (STD): All information about HIV/AIDS and sexually transmitted diseases is protected under Federal and State laws and cannot be disclosed without your written authorization unless otherwise provided in the regulations. To release HIV/AIDS or STD information, this authorization must include a statement of the specific HIV/AIDS or STD information you are giving the Agency permission to disclose. Re-disclosure of HIV/AIDS information is not allowed except in compliance with law or with your written permission.

Alcohol or Drug Treatment: Alcohol and/or drug treatment records are protected under Federal and State laws and regulations and cannot be disclosed without your written authorization, unless otherwise provided for in Federal and State laws or regulations. To release alcohol and/or drug treatment information, this authorization must include a statement of the specific information that you are giving the Agency permission to disclose (for example, "For the purposes of my assessment, treatment plan, attendance, or discharge plan.") Re-disclosure of your alcohol and/or drug treatment records is not allowed except in compliance with law or with your written permission (see 45 CFR Part 2).

Mental Health Treatment: Mental health treatment records are protected under Federal and State laws and regulations and cannot be disclosed without your written authorization unless otherwise allowed in Federal or State laws or regulations. To release mental health treatment information, this authorization must include a statement of the specific information that you are giving the Agency permission to disclose (for example, "For the purposes of my assessment, treatment plan, attendance, or discharge plan.") Disclosure of your psychotherapist's notes needs separate written permission. Re-disclosure of your mental health treatment records is not allowed except in compliance with law or with your written permission.

Revocation of Authorization

To revoke your authorization, please complete the following section and send the form to the Privacy Officer at the address given above. Use of this form to revoke your authorization is optional but your authorization revocation request must be in writing.

Name			Date of Birth		
Phone			Social Security Number		
Medicaid ID Number or Gold Card Number					
Street Address					
City		State		Zip Code	

I hereby revoke my authorization for the Agency for Health Care Administration to disclose my protected health information to the following person(s), group orentity:

Signature		Date	

If the information you are requesting to be disclosed is not about you or your minor child, please complete the section below. If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your legal authority to request this information. (For example, an authorization, power of attorney, guardianship papers, health care surrogate form, Order Appointing Personal Representative, Letters of Administration).

Legal Representative (Signature)			
Legal Representative (Print Name)			
Relationship of Legal Representative		Date	