



AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: _____ Phone #: _____
Address: _____

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: Heart of Florida United Way, Attn: Ryan White Program Phone #: 407-835-0900

METHOD OF DISCLOSURE:

Pick up at Clinic/Facility
 Address: 1940 Cannery Way, Orlando, FL 32804
Fax #: _____
 Email Address: (please note that emailing may not be a secured method of communication)
rwservices@hfuw.org

INFORMATION TO BE DISCLOSED: (Initial Selection)

____ General Medical Record(s), including STD and TB ____ Progress Notes ____ History and Physical Results
____ Immunizations ____ Family Planning ____ Prenatal Records ____ Consultations
____ Diagnostic Test Reports (Specify Type of test(s)) Ryan White-related diagnostics
____ Other: (specify) _____

I specifically authorize release of information relating to: (initial selection)

____ HIV test results for non-treatment purposes ____ Substance Abuse Service Provider Client Records
____ Psychiatric, Psychological or Psychotherapeutic notes ____ Early Intervention ____ WIC

PURPOSE OF DISCLOSURE:

Continuity of Care ____ Personal Use Other (specify) Payment Remittance

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLASURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCAATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

Client/Legal Representative Signature

Date

Printed Name

Legal Representative's Relationship to Client

Witness (optional)

Date

If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your legal authority to the request this information (for example, power of attorney, healthcare surrogate form, order, appointment of a guardianship, order appointing personal representative, letters of administration).

Client Name: _____

ID#: _____

DOB: _____

Original: To File **Copy:** To Client **Copy:** To Accompany Disclosure