

Patient Authorization to Use or Disclose Protected Health Information

1A. _____ Name of Patient	1B. _____ Name of CHC Treating Facility
_____ Address	_____ Address
_____ City, State, Zip Code	_____ City, State, Zip Code
_____ Social Security Number	_____ DOB

2. **Authorizes: (check one)**
_____ **CHC to Release Protected Health Information TO:**
_____ **Release of Protected Health Information TO CHC FROM:**

_____ Name of Health Care Provider/Plan/Other	_____ Telephone number
_____ Street Address	
_____ City, State, Zip Code	_____ fax number

(Information being sent to CHC should be addressed to CHC treating facility shown above at (1B), Attention: Medical Records).

3. **Information To Be Released:**
- | | |
|----------------------------|------------------------------------|
| _____ Medical History | _____ Consultations |
| _____ Examination, Reports | _____ Prescriptions |
| _____ Treatment or Tests | _____ Hospital Records and Reports |
| _____ Immunizations | _____ Entire Record |
| _____ X-ray reports | _____ Other (Specify) |
| _____ Laboratory Reports | _____ |

4. **Purpose of Disclosure (check appropriate categories)**
- | | |
|--------------------------------------|---------------------------|
| _____ Further Medical Care | _____ Legal Investigation |
| _____ Insurance Eligibility/Benefits | _____ or action |
| _____ Other (Specify) | _____ Changing Physicians |
- _____

5. **In compliance with Florida Statutes, which requires special permission to release otherwise privileged information, please release records pertaining to:**
(Initials required)

_____	Psychiatric information 394.459(9)
_____	Drug and/or Alcohol Abuse Information 397.053 and 396.112
_____	HIV/AIDS Information 381.609(2)

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6. Authorization for the period of: _____

7. Expiration date _____
(or) one-time Disclosure _____

Section B: I understand this authorization may be revoked upon written notice to:

Lyn Blankenship, Privacy Officer, Community Health Centers, Inc., 110 South Woodland Street, Winter Garden, Florida 34787. No further disclosures will be made upon notice of revocation, except to the extent that action has already been taken on this authorization.

I also understand that I should immediately contact the healthcare provider/plan /other, if I wish to revoke my authorization to disclose my protected health information to CHC, to ensure the information is not released to CHC.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form, by sending a written request to CHC's Privacy Officer, and that I have the right to a copy of this authorization form.

Patient/Parent/Legal Representative (Signature in full)

Date of Authorization

Translator/Interpreter (Print name, address, phone number)

If not patient – state relationship to patient or authority to sign

Type of Identification presented

01/05/09

PR/RP 3.2