UF UNIVERSITY of FLORIDA

AUTHORIZATION to Use or Disclose Protected Health Information (PHI) - General Purposes

Patient Name			*Verification of Identity (Driver's License, ID Card, Passport, etc.)*
Address			*Health Record Number*
Phone #	*Phone #*	*E-mail Address*	*Date of Birth*

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

Name	*Relationship to Patient*	*Verification of Identity*	*Verification of Authority*
Representative's Address	*Phone #:*	*E-mail Address:*	

See the UF Policy for Verification of Identity and Authority and Personal Representatives in the Operational Guidelines.

By signing this form, I authorize release/disclosure of the patient's health records and information:

From the doctor, office, facility or other health care provider specified below:		**To** the patient, legal representative, doctor, office, facility, or other entity as specified below:	
Name		*Name*	
Address, if known		*Address*	
Attn:	*Phone*	*Attn:*	*Phone*

The protected health information that may be released/disclosed is:

I further authorize the disclosure of the following information, which may be included in the protected health information listed above. (*Check all that are approved*.)

☐ Mental Health	☐ Substance Abuse	☐ STD / HIV/AIDS	☐ Genetic Data	☐ Records created by non-UF/Shands providers

The purpose of the disclosure is:

- I understand that, by federal law, the University of Florida (UF) may not use or disclose protected health information (PHI) without authorization except as provided in UF's Notice of Privacy Practices. By signing this Authorization, I am giving permission for the use or disclosure of the PHI described above. I hereby release UF and its employees from any and all liability that may arise from the release of information as I have directed.
- I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address it to the person or institution named above. The revocation will not apply to any information already released as a result of this authorization.
- I understand that I may refuse to sign this Authorization, and 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.
- I understand that information disclosed pursuant to this Authorization may no longer be protected by federal health information privacy laws and could be re-disclosed by the person or agency that receives it.
- I understand that I may be charged a fee of up to $1.00 per page (plus applicable tax and handling) for every page copied and that this fee is within the limits allowed by Florida law.

This authorization expires automatically one (1) year from the date signed, if no other date or event is specified:
Date or Event _____

This authorization may be used to disclose the same type(s) of health information described above, which may be created in the future, until the expiration date.	☐ YES ☐ NO
Signature of Patient or Legal Representative:	*Date*

Complete all parts of the form, print out and sign and date. Patient or representative should keep a copy. Give, fax, or mail the original form to the person or organization releasing the information.