



REMINDER: **Contact physician office PRIOR to faxing** to alert them the fax is coming and confirm the fax #



AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

NOTE: FORM WILL BE RETURNED IF ALL REQUESTED PERSON/FACILITY INFORMATION IS NOT FILLED IN

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: Collier County Health Department Phone #: 239-252-2686

Address: 3339 Tamiami Trail E., Ste 145, Naples, Fax #: 239-252-8466

FL 34112

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: _____ Phone #: _____

Address: _____ Fax #: _____

Other method of communication: _____

INFORMATION TO BE DISCLOSED: (Initial Selection)

NOTE: ONLY INFORMATION BELOW WHICH HAS BEEN INITIALED WILL BE RELEASED

____ 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)) _____

____ Other: (specify) _____

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

NOTE: ONLY INFORMATION BELOW WHICH HAS BEEN INITIALED WILL BE RELEASED

____ 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) _____

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.

REVOICATION: 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/Representative Signature

Date

Printed Name

Representative's Relationship to Client

Witness (optional)

Date

Client Name: _____

ID#: _____

DOB: _____