



AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: _____ Phone #: _____

Address: _____ Fax #: _____

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: Collier County Health Department Phone #: 239-252-5314

Address: 3301E TAMIAMI TRAIL BLDG H NAPLES, FL 34112 Fax #: 239-252-5396

Other method of communication: _____

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)) _____
- _____ 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) _____

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: _____