

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____
Last First Middle

Home Address: _____

Home Telephone: _____ **Date of Birth:** _____ **Social Security Number:** _____

Specify Information to be Disclosed/Brief Description of PHI Disclosed: (Check one, or all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Face sheet | <input type="checkbox"/> History and Physical | Purpose or use of Disclosure |
| <input type="checkbox"/> Lab test results, specify: _____ | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Continuity of Care |
| <input type="checkbox"/> Radiology test results, specify: _____ | <input type="checkbox"/> Consultation | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> Itemized bill or billing information | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Discharge Medication List | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Other, specify: _____ | | <input type="checkbox"/> Other: _____ |

Dates of service needed: _____

By applying a check next to a category of highly confidential information listed below and signing on the appropriate line after the checked box, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization: (May waive this section of not pertinent)

- | | |
|---|-------|
| <input type="checkbox"/> Mental Illness | _____ |
| <input type="checkbox"/> Developmental Disability | _____ |
| <input type="checkbox"/> Psychotherapy Notes | _____ |
| <input type="checkbox"/> HIV/AIDS Testing or Treatment (regardless of result) | _____ |
| <input type="checkbox"/> Venereal Disease | _____ |
| <input type="checkbox"/> Abuse of an Adult with a Disability | _____ |
| <input type="checkbox"/> Sexual Assault | _____ |
| <input type="checkbox"/> Child Abuse or Neglect | _____ |
| <input type="checkbox"/> Other: _____ | _____ |

RECIPIENT: Name of the person or class of persons to who CLEVELAND CLINIC FLORIDA may disclose my health information:

Name: _____
 Address: _____

TERM: This authorization will remain in effect:

- From the date of this Authorization until the _____ day of _____, 20____.
- Until Covered Entity fulfills this request.
- Until the following event occurs: _____

PURPOSE: I authorize CLEVELAND CLINIC FLORIDA to use or disclose my health information (including the highly confidential I selected above, if any) during the term of this Authorization for the following specific purpose(s): Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization:

I understand that once CLEVELAND CLINIC FLORIDA discloses my health information to the recipient, CLEVELAND CLINIC FLORIDA cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclose of my health information.

I understand the CLEVELAND CLINIC FLORIDA may, directly or indirectly, receive remuneration from a third party in connection with the use or disclose of my health information.

I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at CLEVELAND CLINIC FLORIDA; except, however, if my treatment at CLEVELAND CLINIC FLORIDA is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case CLEVELAND CLINIC FLORIDA may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Cleveland Clinic Florida Privacy Office at the address listed below. The revocation will be effective immediately upon CLEVELAND CLINIC FLORIDA receipt of my written notice, except that the revocation will not have any effect on any action taken by CLEVELAND CLINIC FLORIDA in reliance on this Authorization before it received my written notice of revocation.

I may contact Cleveland Clinic Florida Privacy Office by mail at: Cleveland Clinic Florida, Attn: Privacy Officer, 3100 Weston Road, Weston, Florida 33331, or telephone at 954-689-5072 (c/o HIM Department Director).

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize CLEVELAND CLINIC FLORIDA to use or disclose my health information in the manner described above.

 Signature of Patient

 Date

If patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

 Signature of Personal Representative

 Description of Authority

 Date

For Internal Use Only: The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the PHI records. **Signature of employee validating identity:** _____