UCF ✦ Health
College of Medicine Practice

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: _____ Date of Birth: ___/___/____

Address: _____
(Street) (City, State, Zip Code)

By signing this form, I authorize the use and disclosure of my protected health information by UCF Health, as specified below:

Description of protected health information that UCF Health may disclose:
❑ All healthcare information that may be maintained by UCF Health including treatment records for *(check all that are approved)*: ❑ mental health ❑ drug/alcohol abuse ❑ HIV/AIDS or other communicable diseases ❑ Other: _____
UCF Health may disclose the protected health information to:
Name: _____ (Organization/Person) Address: _____ _____ Attn: _____
The purpose(s) of the disclosure is/are:
❑ At my request ❑ For health care treatment purposes ❑ For payment/insurance ❑ For employment purposes ❑ Other _____

I understand that, by federal law, UCF Health may not use or disclose protected health information without authorization except as provided in UCF Health's Notice of Privacy Practices. By signing this Authorization, I am giving permission for the uses and disclosures of the described protected health information. I hereby release UCF Health and its employees from any 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 by contacting the UCF Health Medical Records Department, 3400 Quadrangle Blvd., Orlando, FL 32817. I understand that the revocation will not apply to any actions already taken as a result of this authorization.
I understand that if the recipient of the information disclosed pursuant to this Authorization is not a health care provider or health plan covered by the federal Privacy Rule, the information may be used or disclosed by the recipient and no longer protected by the Privacy Rule.

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I understand that I am not required to sign this Authorization as a condition of treatment, payment, enrollment or eligibility for benefits.

I understand that my refusal to sign this Authorization for the use or disclosure of health information for purposes of research may affect my ability to receive treatment related to the research.

I understand that UCF Health may refuse to provide me with health care that is solely for the purpose of creating health information for disclosure to a third party if I refuse to sign this Authorization for the disclosure of health information to the third party.

This Authorization expires automatically one (1) year from date signed, if no other date or event is specified.	Expiration Date or Event:
This Authorization may be used to disclose protected health information of the same type described above, which may be created in the future, until the expiration date.	❑Yes ❑ No

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____/_____/_____

Signature of Patient or Patient's Authorized Representative

Date

If signed by the Patient's Representative, please print name and describe relationship to patient or other authority to act:

_____ _____

Name

Relationship to Patient

[A copy of this signed Authorization must be given to the patient or the patient's representative.]

Last revised 9/17/2011