Florida's Choice HEALTH CARE

Florida's Choice Health Care
Authorization to Release, Use, or Disclosure Protected Health

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization permits Florida's Choice Health Care geriatric care transition services access to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Patient Information for whom authorization is made:

Full Name: _____

Other Name(s) Used: _____Date of Birth: _____

Address:_____City:_____State:_____Zip Code:_____

Phone: (_____)_____Email (*Optional*): _____

Medicare Number:_____Social Security Number:_____

Information regarding health care provider or health care entity authorized to disclose this information:

Name: _____

Address:_____City:_____State:_____Zip Code:_____

Phone: (_____)_____Fax: (_____)_____

Specific information to be disclosed:

□ Medical Record from (insert date) _____to (insert date) _____

□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

□ Other: _____

Effective Time Period: This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: _____Day: _____Year: _____.

Right to Revoke: I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action

Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____