HIPAA Release Form Florida

HIPAA RELEASE FORM FLORIDA

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid, and it will not be possible for your health information to be shared as requested.

SECTION I

Authorization

SECTION II - HEALTH INFORMATION

I would like to give the above healthcare organization permission to:

Tick as appropriate:

- ◯ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.
- ◯ Disclose my complete health record except for the following information (specify below)

Specify the exemptions (if applicable):

- ☐ Mental health records
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Alcohol/drug abuse treatment records
- ☐ Genetic information
- ☐ Other

Form of disclosure:

◯ Electronic copy or access via a web-based portal ◯ Hard copy

SECTION III - REASON FOR DISCLOSURE

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request.'

SECTION IV - WHO CAN RECEIVE MY HEALTH INFORMATION

I give authorization for the health information detailed in Section II of this document to be shared with the following individual(s) or organization(s):

Name: _____ **Organization:** _____

Address: _____

☐ I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

SECTION V - DURATION OF AUTHORIZATION

This authorization to share my health information is valid:

Tick as appropriate:

◯ From [Date 1] to [Date 2] ◯ All past, present, and future periods
◯ The date of the signature in Section VI until the following event (specify in the space provided)

Specify dates: _____ **Specify event:** _____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: _____ **Organization:** _____

Address: _____

☐ I understand that: In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data. I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in Section IV.

SECTION VI - SIGNATURE

Signature:
Date: _____ dd / mm / yyyy **Print your name:** _____

If this form is being completed by a person with legal authority to act on an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form:
Describe below how this person has legal authority to sign this form: