AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION
LA RABIDA CHILDREN'S HOSPITAL

Patient's Name: _____ **MR#:** _____
Last First
Home Address: _____
_____
Home Telephone: _____ **Date of Birth:** _____

SPECIFY INFORMATION TO BE DISCLOSED:
☐ Inpatient ☐ Outpatient Dates of Service: _____
The information that may be disclosed under this Authorization includes:
_____

MY HIGHLY CONFIDENTIAL INFORMATION:
By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

☐ Psychological Records, evaluations and/or treatment for mental, physical and/or emotional illness
☐ Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
☐ Information about Venereal Disease(s)
☐ Information about Substance (i.e., alcohol or drug) Abuse
☐ Information about Sexual Assault/Child Abuse and Neglect
☐ Information about Genetic Testing

I hereby authorize that the protected health information regarding the above named person be forwarded to:
RECIPIENT:

RECIPIENT/TO: Person/Institution _____
Address: _____
City_____**State**_____**Zip Code**_____
Attention to: _____

I also understand that this Authorization is subject to revocation/withdrawal by me at any time by submitting in writing to the medical record contact person or Chief Privacy Officer except to the extent that action has already been taken to release this information. This authorization shall remain valid unless revoked but will expire in 1 year after signing. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

REDISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization that La Rabida Children's Hospital cannot guarantee that the Recipient receiving the requested health information will not redisclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.

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, I hereby, knowingly and voluntarily authorize La Rabida Children's Hospital to use or disclose my health information in the manner described above.

_____ _____
Signature of Patient Date Signature of Witness* Date

**Witness' Signature required for release of information about a mental illness or developmental disability*

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

_____ _____ _____ _____ _____
Signature of Legal Guardian or other authorized Personal Representative | Relationship to Patient | Date | Signature of Witness* | Date