**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL OR PROTECTED HEALTH INFORMATION**
**Orange County Corrections Health Services Division**

PO Box 4970
Orlando, Fl. 32802
(407) 254-8306 Fax (407) 836-3241

I, _____ hereby authorize _____, its employees or agents, to release copies of my Confidential or Protected Health Information, ("PHI"), to the following individual(s), healthcare provider(s), entity(ies) or agency(ies).

Name(s) and address of individual, healthcare provider(s) entity (ies), or agency (ies) to receive the Confidential or PHI:

_____

_____

For the purpose of:

_____
(A statement "at the request of the individual" is sufficient if the client signs this Authorization and does not wish to give a specific reason.)

The specific information to be disclosed shall include: (Please check all that apply)

- ☐ Complete Record
- ☐ Abstract
- ☐ Progress notes
- ☐ Mental Health
- ☐ History & Physical
- ☐ Prenatal
- ☐ Lab/X-ray/Diagnostic results
- ☐ Other (specify)_____

By initialing below I understand documentation originated at OCC Health Services may contain questions regarding medical history that may be considered Super Confidential, I further understand by not initialing below OCC Health Services cannot comply with my request for a complete record release.

_____ Mental Health (Initial) _____HIV Testing /AIDS Information (Initial) _____ Drug and/or Alcohol Abuse (Initial)

Date(s) of service: _____

I understand that I may select which information may be released by placing my initials in the area provided. PHI is confidential and protected by federal regulations, which prohibit further disclosure without specific written authorization from me or as otherwise permitted by federal and state law. I understand that this Authorization may be revoked upon written notice to the following address _____ except to the extent that action has already been taken in reliance on this Authorization. This Authorization may be revoked by writing or faxing and specifying the date this Authorization was signed. This Authorization will expire one year from today's date unless an expiration date or event is indicated.
I understand that this authorization is voluntary and that I may refuse to sign it. I further understand that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria.

Date of authorization: _____ Expiration date of authorization: _____

Patient DOB: _____ Booking # _____

_____ Patient/Parent/Legal Representative (Printed)

_____ Patient/Parent/Legal Representative (Signature)