Authorization for the Use and Disclosure of Protected Health Information

Information Identifying the Individual Whose Records Are Being Requested

Name of Individual: _____ SSN: _____

Disclosure of your Social Security Number is not mandatory. The Agency for Health Care Administration (AHCA or Agency) may request your Social Security Number pursuant to Section 119.071, Florida Statutes. If provided, the Agency will use your information for purposes of finding the requested information.

Individual's Street Address: _____

City: _____ State: _____ Zip Code: _____

Medicaid ID or Gold Card Number: _____

Phone Number: _____ Date of Birth: _____

Provide the *specific* dates of service included. From: _____ To: _____

Purpose for this disclosure: _____

Date I wish this authorization to expire (expires in one year if no date is provided): _____

☐ **I direct AHCA to mail the requested hard copy records to the below person(s), group or entity:**

Documents Requested: ☐ Paid Claims Records ☐ Denied Claims Records ☐ All Claims Records

☐ Other: _____

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

☐ **I authorize the below person(s), group or entity to verbally discuss specific topics with AHCA:**

The *specific* topics to be discussed are: _____

Name: _____

I understand the following: I have the right to revoke this authorization at any time by writing to the Agency's Privacy Officer or completing the revocation section on the second page of this form and sending it to the address listed for the Agency's Privacy Officer. I understand that any information previously disclosed would not be subject to my revocation request. The information described above may be re-disclosed by the person or group that I am giving the Agency permission to disclose to and therefore my information may no longer be protected by Federal privacy regulations. I may inspect or request copies of any information disclosed by this authorization if the Agency initiated this request for disclosure. I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment, payment for health care services or eligibility for benefits.

This form specifically includes authorization to provide documents related to sensitive health conditions including: drug, alcohol or substance abuse, psychological or psychiatric treatment, sickle cell anemia, birth control or family planning, genetic diseases or tests, tuberculosis, and HIV/AIDS or STDs. **To restrict sensitive information, see Page 2.**

I DECLARE UNDER PENALTY OF LAW THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

Signature: _____ Date: _____

Printed Name: _____

Legal Authority (If Other Than Individual): _____

If you are a legal representative of the person whose information you are requesting disclosure of, you must provide documentation proving your legal authority to request this information (for example, power of attorney, guardianship papers, health care surrogate form, Custody Order, Order Appointing Personal Representative, Letters of Administration).

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Instructions for Completing this Form

1. Complete the first page of this form and return it to: **HIPAA Privacy Officer, Agency for Health Care Administration, 2727 Mahan Dr., MS #4, Tallahassee, FL 32308, Phone: 850-412-3960, Fax 850-414-6837**
Email: HIPAAComplianceOffice@AHCA.MyFlorida.com.

2. Special types of health information have specific laws and rules that must be followed before that information may be disclosed:

HIV/AIDS and Sexually Transmitted Diseases (STD): All information about HIV/AIDS and sexually transmitted diseases is protected under Federal and State laws and cannot be disclosed without your written authorization unless otherwise provided in the regulations. To release HIV/AIDS or STD information, this authorization must include a statement of the specific HIV/AIDS or STD information you are giving the Agency permission to disclose. Re-disclosure of HIV/AIDS information is not allowed except in compliance with law or with your written permission. **To NOT INCLUDE this information, initial here _____**

Alcohol or Drug Treatment: Alcohol and/or drug treatment records are protected under Federal and State laws and regulations and cannot be disclosed without your written authorization, unless otherwise provided for in Federal and State laws or regulations. To release alcohol and/or drug treatment information, this authorization must include a statement of the specific information that you are giving the Agency permission to disclose (for example, "For the purposes of my assessment, treatment plan, attendance, or discharge plan.") Re-disclosure of your alcohol and/or drug treatment records is not allowed except in compliance with law or with your written permission (see 45 CFR Part 2). **To NOT INCLUDE this information, initial here _____**

Mental Health Treatment: Mental health treatment records are protected under Federal and State laws and regulations and cannot be disclosed without your written authorization unless otherwise allowed in Federal or State laws or regulations. To release mental health treatment information, this authorization must include a statement of the specific information that you are giving the Agency permission to disclose (for example, "For the purposes of my assessment, treatment plan, attendance, or discharge plan.") Disclosure of your psychotherapist's notes needs separate written permission. Re-disclosure of your mental health treatment records is not allowed except in compliance with law or with your written permission. **To NOT INCLUDE this information, initial here _____**

Revocation of Authorization

DO NOT COMPLETE FOR A NEW AUTHORIZATION. THIS SECTION IS ONLY FOR REVOKING A PREVIOUS AUTHORIZATION. Disclosure of your Social Security Number is not mandatory. The Agency for Health Care Administration may request your Social Security Number pursuant to Section 119.071, Florida Statutes.

Name			Date of Birth		
Phone			Social Security Number		
Medicaid ID Number or Gold Card Number					
Street Address					
City		State		Zip Code	

I hereby revoke my authorization for the Agency for Health Care Administration to disclose my protected health information to the following person(s), group or entity:

Signature		Date	
Printed Name		Legal Relationship to Individual	

If you are the subject's legal representative, you must provide documentation proving your legal authority to revoke this authorization. (For example, an authorization, power of attorney, guardianship papers, health care surrogate form, Order Appointing Personal Representative, Letters of Administration).