Cleveland Clinic
Florida

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____
Last **First** **Middle**

Home Address: _____

Home Telephone: _____ **Date of Birth:** _____ **Social Security Number:** _____

Specify Information to be Disclosed/Brief Description of PHI Disclosed: (Check one, or all that apply)

☐ Face sheet
☐ Lab test results, specify: _____
☐ Radiology test results, specify: _____
☐ Entire Medical Record
☐ Emergency Room Record
☐ Other, specify: _____

☐ History and Physical
☐ Discharge Summary
☐ Consultation
☐ Itemized bill or billing information
☐ Discharge Medication List

Purpose or use of Disclosure
☐ Continuity of Care
☐ Personal
☐ Legal
☐ Insurance
☐ Other: _____

Dates of service needed: _____

By applying a check next to a category of highly confidential information listed below and signing on the appropriate line after the checked box, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization: (May waive this section of not pertinent)

☐ Mental Illness _____
☐ Developmental Disability _____
☐ Psychotherapy Notes _____
☐ HIV/AIDS Testing or Treatment (regardless of result) _____
☐ Venereal Disease _____
☐ Abuse of an Adult with a Disability _____
☐ Sexual Assault _____
☐ Child Abuse or Neglect _____
☐ Other:_____ _____

RECIPIENT: Name of the person or class of persons to who CLEVELAND CLINIC FLORIDA may disclose my health information:
Name: _____

Address: _____

TERM: This authorization will remain in effect:
☐ From the date of this Authorization until the _____ day of _____, 20_____.
☐ Until Covered Entity fulfills this request.
☐ Until the following event occurs:_____

PURPOSE: I authorize CLEVELAND CLINIC FLORIDA to use or disclose my health information (including the highly confidential I selected above, if any) during the term of this Authorization for the following specific purpose(s): Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization:
_____.

I understand that once CLEVELAND CLINIC FLORIDA discloses my health information to the recipient, CLEVELAND CLINIC FLORIDA cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclose of my health information.
I understand the CLEVELAND CLINIC FLORIDA may, directly or indirectly, receive remuneration from a third party in connection with the use or disclose of my health information.
I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at CLEVELAND CLINIC FLORIDA; except, however, if my treatment at CLEVELAND CLINIC FLORIDA is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case CLEVELAND CLINIC FLORIDA may refuse to treat me if I do not sign this Authorization.
I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Cleveland Clinic Florida Privacy Office at the address listed below. The revocation will be effective immediately upon CLEVELAND CLINIC FLORIDA receipt of my written notice, except that the revocation will not have any effect on any action taken by CLEVELAND CLINIC FLORIDA in reliance on this Authorization before it received my written notice of revocation.

I may contact Cleveland Clinic Florida Privacy Office by mail at: Cleveland Clinic Florida, Attn: Privacy Officer, 3100 Weston Road, Weston, Florida 33331, or telephone at 954-689-5072 (c/o HIM Department Director).

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 below, I hereby, knowingly and voluntarily, authorize CLEVELAND CLINIC FLORIDA to use or disclose my health information in the manner described above.

_____ _____
Signature of Patient Date

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

_____
Signature of Personal Representative

_____ _____
Description of Authority Date

For Internal Use Only: The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the PHI records. **Signature of employee validating identity:**_____