

AUTHORIZATION FOR VERBAL DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name	Date of Birth	Medical Record Number
Verification of Identity		Social Security Number

** Complete the following only if the person signing this authorization is not the patient:

Name of Person Signing this Authorization	Relationship to Patient	Legal Authority
Verification of Identity		Verification of Authority

By signing this form, I authorize _____
Person or class of persons authorized to disclose the information (eg – physician, provider, office staff)

To disclose to _____
Person or persons to whom disclosure will be made (eg – spouse, children, language translator, care giver)

The following protected health information (eg – diagnosis, test results, medications, treatment options, test requirements, all healthcare services) _____

The purpose of the use or disclosure is: _____
Describe each purpose of the requested use or disclosure (eg – patient doesn't understand, patient doesn't speak English, someone other than parent brings in minor child)

I understand that, with certain exceptions, I have the right to revoke this Authorization at any time. If I want to revoke this authorization, I must do so in writing. The procedure for how I may revoke the authorization, as well as the exceptions to my right to revoke, are explained in University of Florida Health Science Center Notice of Privacy Practices, a copy of which has been provided to me.

I understand that I may refuse to sign this Authorization. I also understand that University of Florida Health Science Center cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this Authorization.

I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

This authorization expires automatically upon _____
Date or Event (eg – 1 visit, 6 months, 1 year)

I have read and understand the information in this authorization form.

Signature of Patient or Legal Representative: _____

Please print name: _____ Date: _____