

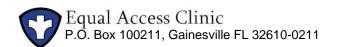


AUTHORIZATION to Use or Disclose Protected Health Information! Instructions

In order to authorize the Equal Access Clinic to use or disclose protected health information you must do the following:

- Complete the following form in its entirety
- Attach a photocopy of valid proof of identity (drivers license, passport, or any other government-issued photo identification)
- Mail both documents to: Equal Access Clinic Records Request P.O. Box 100211 Gainesville, FL 32601





Patient's Name		Date of Birth		Verification of Identity (Driver's License, ID Card, Passport, etc.)			
							Patient's Address
**Complete the followin	g if the person au	ıthorizi	ng the use or dis	closure	is not the	patient:	
Representative's Name			Relationship to Patient		Legal Auth	Legal Authority	
Representative's Address			Verification of Identity		Verification of Authority		
By signing this form, l	I authorize the fo	llowir	ւ ւց։				
Disclosure of the patient's PHI from:			Disclosure of the patient's PHI to:				
Person, class of persons, or organization			Person, class of persons, or organization				
Address			Address				
Attn:	Phone		Attn:		Phone		
The following protected he					1. 4- > 5.00		
I further authorize the dis information listed above. (_	•	e include	a in the pro	tected nealth	
. Mental Health	Substance Abus	se	Records created by non- HIV/AIDS UF/Shands providers			•	
The purpose of this disclosu	ure is:						
I understand that, by federal law, th provided in the University's Notice the described protected health infor from the release of information as I and address it to the person or institute of this Authorization. I understand the provide treatment, payment, enroll pursuant to this Authorization may that receives it. I understand that I retail this fee is within the limits allow.	of Privacy Practices. By si rmation. I hereby release the have directed. I understantitution named above. I und that I may refuse to sign the lment in a health plan, or one longer be protected by may be charged a fee of upwed by Florida law.	singing this the University and that I had derstand the his Authorical eligibility to the federal p to \$1.00	s Authorization, I am givir sity of Florida and its empave the right to revoke this hat the revocation will not ization, and that the instit for benefits if I refuse to al medical privacy law and per page (plus applicable)	ng permissioloyees from s Authoriza apply to ar autions nam sign. I und d could be e tax and h	ion for the use m any and all listion at any time my actions alread above cannot derstand that in disclosed by the	es and disclosures of ability that may aris- e, if I do so in writing ady taken as a resu- not deny or refuse to information discloses he person or agenc- rery page copied and	
This authorization expires automatically one (1) year from the date signed, if no other date or event is specified This authorization may be used to disclose protected health information of the same type described					Date or Ev	rent	
This authorization may be used to above, which may be creased in	ion of the same type desc	cribed	.YES	.NO			
I have re	ead and understand	the info	ormation in this aut	horizati	on form.		
Signature of Patient or Legal Representative:			Date				