Authorization for the Use and Disclosure of Protected Health Information

Please note that Medicaid regulations restrict the use and disclosure of information concerning Medicaid applicants and recipients to purposes directly connected with the administration of the Medicaid State Plan (see 42 United States Code 1396(a)(7)).					
Please provide the following information about the person whose Medicaid records are to be disclosed.					
Name		Social Security Number			
Disclosure of your Social Security Number is not mandatory for purposes of completing this form. However, the Agency for Health Care Administration may request your Social Security Number pursuant to Section 119.071, Florida Statutes. Should you choose to provide your Social Security Number as requested, the Agency shall use your information for purposes of finding the requested information.					
Phone		Date of Birth			
Medicaid ID Number or Gold Card Number					
Street Address					
City		State		Zip Code	
I authorize the Agency for Health Care Administration to share the health information listed below with the following person(s), group or entity:					
Describe the *specific* information that you are giving the Agency permission to disclose (for example, "A report showing the health care services Medicaid has paid for from May 2008 to October 2008.")					
The information described above is to be disclosed for the following purpose (For example, "Treatment of my health condition" or "For legal representation in my medical malpractice lawsuit.")					
Please enter the date you want this authorization to expire (authorization will expire in one year if no date is provided):		Expiration Date			
I understand that the information described above may be redisclosed by the person or group that I am giving the Agency permission to disclose and therefore my information may no longer be protected by Federal privacy regulations. I understand that I may inspect or request copies of any information disclosed by this authorization if the Agency initiated this request for disclosure. I understand that I may revoke this authorization by notifying the Agency in writing with the understanding that previously disclosed information would not be subject to my revocation request. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for health care services or eligibility for benefits.					
<u>You have the right to revoke this authorization at any time</u> 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.					
Signature		Date			
If the information you are requesting to be disclosed is not about you or your minor child, please complete the section below. If you are a legal representative of the person whose information is to be disclosed, you must provide documentation proving your legal authority to request this information. (For example, an authorization, power of attorney, guardianship papers, health care surrogate form, Order Appointing Personal Representative, Letters of Administration).					
Legal Representative (Signature)					
Legal Representative (Print Name)					
Relationship of Legal Representative		Date			

Instructions for Completing the Authorization for the Use and Disclosure of Protected Health Information Form

1. Complete the first page of this form and return it to: HIPAA Privacy Officer, Agency for Health Care Administration, 2727 Mahan Dr., Mail Stop #4, Tallahassee, FL 32308, Phone: 850-412-3960.

2. If the signer is a legal representative, guardian, health care surrogate or has power of attorney, documentation of the representative's legal authority to act on behalf of the individual whose information is to be disclosed must be attached with the authorization form. If an agency has custody of a child and a representative signs the release, include a copy of the custody order.

3. 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. Redisclosure of HIV/AIDS information is not allowed except in compliance with law or with your written permission.

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.") Redisclosure 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).

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. Redisclosure of your mental health treatment records is not allowed except in compliance with law or with your written permission.

Revocation of Authorization

To revoke your authorization, please complete the following section and send the form to the Privacy Officer at the address given above. Use of this form to revoke your authorization is optional but your authorization revocation request must be in writing.

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	

If the information you are requesting to be disclosed is not about you or your minor child, please complete the section below. If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your legal authority to request this information. (For example, an authorization, power of attorney, guardianship papers, health care surrogate form, Order Appointing Personal Representative, Letters of Administration).

Legal Representative (Signature)			
Legal Representative (Print Name)			
Relationship of Legal Representative		Date	