AUTHORIZATION FOR RELEASE OF CONFIDENTIAL OR PROTECTED HEALTH INFORMATION Orange County Corrections Health Services Division

PO Box 4970 Orlando, Fl. 32802 (407) 254-8306 Fax (407) 836-3241

l,	hereby authorize	, its employees or
agents, to release copies of my Conf provider(s), entity(ies) or agency(ies)	idential or Protected Health Information, ("PH	I"), to the following individual(s), healthcare
Name(s) and address of individual, h	ealthcare provider(s) entity (ies), or agency (i	es) to receive the Confidential or PHI:
For the purpose of:		
(A statement "at the request of the individ	ual" is sufficient if the client signs this Authorization	and does not wish to give a specific reason.)
The specific information to be disclosed Complete Record Abstract Progress notes Mental Health	ed shall include: (Please check all that apply	sults
medical history that may be cons		Services may contain questions regarding stand by not initialing below OCC Health
Mental Health (Initial)	HIV Testing /AIDS Information I (Initial)	Drug and/or Alcohol Abuse
Date(s) of service:		
protected by federal regulations, w	hich prohibit further disclosure without spe	y initials in the area provided. PHI is confidential and ecific written authorization from me or as otherwise revoked upon written notice to the following address except to the extent that action has
Authorization was signed. This Authorization was signed. This Authorization will not affect my ability to obtain	orization will expire one year from today's dat n is voluntary and that I may refuse to si	voked by writing or faxing and specifying the date this e unless an expiration date or event is indicated. gn it. I further understand that my refusal to sign eligibility for benefits unless the information is
Date of authorization:	Expiration date of authorization	n:
Patient DOB:	Booking #	_
Detion#/Descript/Laward	in (Printed)	
Patient/Parent/Legal Representat	ive (Printed) Patient/Parent	/Legal Representative (Signature)

Revised: 7/15/14