UNIVERSAL PATIENT AUTHORIZATION FORM FOR LIMITED DISCLOSURE OF HEALTH INFORMATION

****PLEASE READ THE ENTIRE FORM, ALL THREE PAGES, BEFORE SIGNING BELOW****

Individual (name and information of person whose health information is being disclosed):

Name (First Middle Last):_____

Date of Birth (mm/dd/yyyy): _____

Address: _____City:_____ State: FL Zip:_____

You may use this form to allow limited access to and use of your health information by certain persons for certain purposes. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure (including paper, oral and electronic interchange):

OF WHAT: (initial one)

_____ **ALL MY HEALTH INFORMATION including information about sensitive conditions (if any). Health information includes, but is not limited to, all records and other information regarding my health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain information about my health. This includes my specific permission to release any and all of the following information:**

a. Drug, alcohol, or substance abuse
b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
c. Sickle cell anemia
d. Birth control and family planning
e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
f. Genetic (inherited) diseases or tests
g. Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.

_____ ONLY THE INFORMATION INDICATED BELOW (initial next to all that you want disclosed):

_____ History and Physical _____ Operation Reports _____ Discharge Summary _____ Radiology Reports & Images
_____ Pathology Reports _____ EKG Reports _____ Progress Notes _____ Consultation Reports
_____ Lab Results _____ Physician's Orders _____ Drug, Alcohol or Substance Abuse Records
_____ Family Planning Records _____ Prenatal Records
_____ Mental Health Records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
_____ Diagnostic Test Reports (specify type of test): _____
_____ Other (please specify): _____

Note: Information created before or after the date of this form may be disclosed, unless you specify a date range of records here:
From (mm/dd/yyyy): _____ To (mm/dd/yyyy) : _____.

FROM WHOM: (choose one)

☐ **All information sources,** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

☐ **Only the following specific sources of my health information**:

Person/Organization Name: Partners in Medicine & Surgery, P.A. d/b/a 360 Dermatology Phone: (813) 406-4835
Address: 2441 Oak Myrtle Lane, Suite 101, Wesley Chapel, FL 33544 Fax: (____)____
Person/Organization Name:_____ Phone: (____)____
Address:_____ Fax: (____)____
Person/Organization Name:_____ Phone: (____)____
Address:_____ Fax: (____)____
Person/Organization Name:_____ Phone: (____)____
Address:_____ Fax: (____)____

Person/Organization Name:_____ Phone: (____)____
Address:_____ Fax: (____)____
Person/Organization Name:_____ Phone: (____)____
Address:_____ Fax: (____)____

TO WHOM: (check one)

☐ Specific person(s) or organization(s) permitted to receive my information:

Person/Organization Name:_____ Phone: (____)____
Address:_____ Fax: (____)____
Person/Organization Name:_____ Phone: (____)____
Address:_____ Fax: (____)____
Person/Organization Name:_____ Phone: (____)____
Address:_____ Fax: (____)____
Person/Organization Name:_____ Phone: (____)____
Address:_____ Fax: (____)____
Person/Organization Name:_____ Phone: (____)____
Address:_____ Fax: (____)____
Person/Organization Name:_____ Phone: (____)____
Address:_____ Fax: (____)____

PURPOSE: (check all that apply)

☐ My medical treatment and related services and products
☐ To evaluate and improve patient safety and the quality of medical care provided to all patients
☐ Payment (as defined in HIPAA at 45 CFR 164.501)
☐ Eligibility for certain health care services (e.g., hospice)(please specify: _____)
☐ Eligibility for clinical trials (if limited, please specify here:_____)
☐ Scientific research with proper Institutional Review Board approval or waiver
☐ Personal Health Record for my use
☐ Personal use
☐ Other, please specify: Transfer of care

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until (check one):

☐ The day I withdraw my permission or the date of my death
☐ A specific date (mm/dd/yyyy): _____
☐ A specific event. Please specify: _____

REVOKING YOUR PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization to whom I originally gave this form.

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read all pages of this form and agree to the disclosures above from the types of sources listed**.

X_____ _____

Signature of Patient or Patient's Legal Representative Date Signed (mm/dd/yyyy)

_____

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

☐ Parent of minor
☐ Guardian
☐ Other personal representative (explain: _____)

This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Further Explanation of Form Florida AHCA FC4200-005
"Universal Patient Authorization Form for Limited Disclosure of Health Information"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

Definitions: In this form, the term "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501).

Note on Mental Health Records: If you are requesting a copy of your mental health records with this form, Florida allows such access, unless such access is determined by your physician to be harmful to you. For more information, see Florida Statute 394.4615(10).

"To Whom":

- If you specified a healthcare provider in the "TO WHOM" section above, this permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified.
- If you specified an organization other than a healthcare provider in the "TO WHOM" section above, this permission would also include that organization's staff or agents and subcontractors who carry out activities and purpose(s) permitted by this form for that organization that you specified.

Revocation: You have the right to revoke this authorization and withdraw your permission at any time regarding future uses by giving written notice. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

Re-disclosure of Information: Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want all of your health information shared with your healthcare provider for treating you, you need to use Form Florida AHCA FC4200-004 (Universal Patient Authorization Form For Full Disclosure of Health Information For Treatment & Quality of Care), instead of this form. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.