UF UNIVERSITY of FLORIDA

AUTHORIZATION to Use or Disclose Protected Health Information (PHI)

Patient's Name	Date of Birth	Verification of Identity (Driver's License, ID Card, Passport, etc.)
Patient's Address	Medical Record Number	

** Complete the following only if the person authorizing the use or disclosure is not the patient:

Representative's Name	Relationship to Patient	Legal Authority
Representative's Address	Verification of Identity	Verification of Authority

By signing this form, I authorize the following:

Disclosure of the patient's PHI **from**:		Disclosure of the patient's PHI **to**:	
Person, class of persons, or organization UF COllege of Dentistry		*Person, class of persons, or organization*	
Address P.O. Box 100425		*Address*	
Gainesville Fl, 32610-0425			
Attn: Dental Records	*Phone* 352-273-6812	Attn:	*Phone*

The following protected health information may be disclosed:

I further authorize the disclosure of the following information which may be included in the protected health information listed above. (*Check all that are approved*.)

☐ Mental Health	☐ Substance Abuse	☐ HIV/AIDS	☐ Records created by non-UF/Shands providers

The purpose of the disclosure is:

I understand that, by federal law, the University of Florida may not use or disclose protected health information without authorization except as provided in the University's Notice of Privacy Practices. By signing this Authorization, I am giving permission for the uses and disclosures of the described protected health information. I hereby release the University of Florida and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address it to the person or institution named above. I understand that the revocation will not apply to any actions already taken as a result of this authorization.

I understand that I may refuse to sign this Authorization, and that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

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

I understand that I may be charged a fee of up to $1.00 per page (plus applicable tax and handling) for every page copied and that this fee is within the limits allowed by Florida law.

This authorization expires automatically one (1) year from the date signed, if no other date or event is specified.	*Date or Event*
This authorization may be used to disclose protected health information of the same type described above, which may be created in the future, until the expiration date.	☐ YES ☐ NO
I have read and understand the information in this authorization form.	
Signature of Patient or Legal Representative:	*Date*