

**WINDMOOR HEALTHCARE**  
11300 U.S. 19 North CLEARWATER, FL 33764  
727-541-2646      FAX: 727-322-7205

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

I authorize **Windmoor Healthcare** to release general medical, as well as HIV test results, psychiatric, alcohol, drug abuse information from my health record in accordance with *Florida Statutes 394.459 and/or 90.503 and Federal Regulations (42CFR Part 2) and/or HIPAA (CFR164.508)*. **"Release"** may be **(check all that apply)**:

- copies of records    review of records    verbal exchange of information.

**TO:** (name/address/phone #) \_\_\_\_\_

**Information is to be used for:** \_\_\_\_\_

**A general medical authorization and subpoena duces tecum without a specific authorization to release HIV test results/psychiatric/alcohol/drug abuse information must have this waiver from the client or his/her empowered representative.**

**The below listed information is \_\_\_ to be obtained and/or \_\_\_ to be forwarded as follows:**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> History & Physical | <input type="checkbox"/> HIV test results |
| <input type="checkbox"/> Psychosocial      | <input type="checkbox"/> Progress Notes         | <input type="checkbox"/> Radiology reports  | <input type="checkbox"/> Lab results      |
| <input type="checkbox"/> Medications       | <input type="checkbox"/> Financial Information  | <input type="checkbox"/> Other: _____       |   |

I understand that I have the right to refuse to sign this authorization and that the facility named above is released from all legal liability that may arise from not releasing the information requested.

This consent is subject to revocation at any time except to the extent that the facility which is to make the disclosure has already taken action in reliance on it. **This authorization will expire one year from the date signed.**

I hereby release Windmoor Healthcare from liability which may arise as a result of the use of information disclosed by this authorization, should it be presumed that such information is later used to my detriment.

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**EMPOWERED REPRESENTATIVE SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
(If patient is unable to sign) Legal guardianship must be substantiated with legal documentation accompanying this authorization.

**WITNESS SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PROHIBITION ON REDISCLOSURE:** This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42CFR Part 2) strictly prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of clinical or medical information if held by another party is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol/drug abuse patient. The confidentiality of HIV antibody test results is protected by Florida Law (FL STAT.ANN.381.609(2)(F) which prohibits any further disclosure without specific written consent of the patient or as otherwise permitted by state law.

All requests for patient health information will be maintained in the patient's medical record indefinitely or until the record is destroyed in accordance with the record retention guideline.

**A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL**

LABEL

FILE IN LEGAL SECTION

HIM005 (Revised 6/2013)