

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize _____ (“Provider”) to disclose protected health information (“PHI”) regarding:
Patient Name: _____ Patient Date of Birth: _____
Patient Address: _____

I authorize the PHI be disclosed at my individual request to **Horizons of Okaloosa County, Inc. DBA The Arc of the Emerald Coast** at the following location:

123 Truxton Avenue Fort Walton Beach, FL 32547 Phone: (850)863-1530 Fax: (850)862-4589

Check one:

I authorize the following PHI to be released:

- All health information about the patient in the possession of Provider, including, but not limited to psychiatric, mental health treatment information excluding psychotherapy notesⁱ, HIV test results, genetic testing information or alcohol or drug treatment information;
- For a limited time period beginning _____ and ending _____ all health information about the patient in the possession of Provider, including, but not limited to psychiatric, mental health treatment information excluding psychotherapy notes, HIV test results, genetic testing information or alcohol or drug treatment;
- Limited PHI about the patient in the possession of Provider to exclude the following information which I request not be disclosedⁱⁱ: _____

- Other, as described here _____

I understand and acknowledge the following statements:

1. I may revoke this authorization at any time by notifying the Provider in writing of the revocation, unless the Provider has already relied on this authorization to disclose PHI;
2. PHI disclosed may be subject to re-disclosure and no longer be protected by federal or state privacy laws;
3. I am signing this authorization voluntarily. I may decline to sign this authorization. However, refusal to sign does not stop the Provider’s disclosure of PHI that is otherwise permitted to be disclosed by law without my specific authorization;
4. Provider will not condition my treatment on whether I sign, or refuse to sign, this authorization;
5. I will receive a signed copy of this form.
6. I understand that unless otherwise revoked, this authorization will expire one year after the patient is discharged from Provider’s care.

Check one:

- I am the patient and I understand and agree to the provisions of this authorization.
- I understand and agree to the provisions of this authorization on behalf of the patient named above. I have signed my name individually as the parent of a minor patient **OR** as the representative of the adult patient and have attached, or previously provided, a copy of the document authorizing me to serve as the patient’s legal representative.

Signature of Patient or Legal Representative	Date
Signature of Parent/Legal Representative/Competent Adult (if applicable)	Date
Signature of Witness	Date

ⁱ Psychotherapy notes are notes by a mental health professional documenting private counseling stored separately from the chart. To release them requires a separate release.
ⁱⁱ The Provider is authorized by law to use or disclose PHI for a variety of reasons without the patient’s authorization. Please see the Provider’s Notice of Privacy Practices for details.