Authorization to Use and Disclose Protected Health Information

Patient's Name:_____ Dates of Treatment:_____

DOB:_____ **SS#:**_____ Phone:_____

I acknowledge and hereby consent to release information from my health record including psychiatric and alcohol/drug abuse treatment information. I understand that my records are protected under Federal and State regulations governing the confidentiality and privacy of health information under CFR 45, CFR 42 Part 2, FS 394, 397, 381 and 90.503 cannot be disclosed without my written authorization unless provided for by the regulations. I further understand that the disclosed information may contain additional information pertaining to the following:

- Acquired Immunodeficiency Syndrome (AIDS)/Human Immunodeficiency Virus (HIV) _____(initial)
- Sexually Transmitted Diseases (STDS) _____(initial)

Please check the information you want disclosed:

☐ Discharge/Continued Care Summary ☐Psychiatric Evaluation ☐ History & Physical
☐ Labs & X-Ray Results ☐Psychosocial Assessment ☐Medication Evaluation
☐Dates of Treatment Letter ☐Other (Please specify):_____

To Whom I authorize ACTS, Inc. to make disclosure to are identified below:

(RELEASE TO) (RECEIVE FROM) (EXCHANGE WITH)

- Please circle one of the above -

Name:_____ Relationship:_____

Telephone:_____ Fax Number:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Type of Disclosure: ☐ Written ☐Verbal ☐Fax ☐Electronic

The information that I am authorizing for disclosure will be used for the following purpose:

☐ Continuity of Healthcare Treatment ☐Education ☐ Insurance/Disability ☐ Legal Reasons ☐ My Personal Records

This consent will expire on the following date, event or condition: _____

If I fail to specify an expiration date, event or condition, this authorization will expire automatically in one year.

I understand that:

- I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing at:
  - 3450 Buschwood Park Drive Tampa, FL 33618 (I understand that the revocation will not apply to information that has already been disclosed in response to this authorization).
- If the requester or receiver is not a health plan or healthcare provider, then the disclosed information may no longer be protected by Federal Privacy Regulations and may be re-disclosed.
- I am entitled to receive a copy of this authorization.
- I may refuse to sign this authorization, and my refusal to sign will not affect my ability to obtain treatment, payment or eligibility for benefits.
- I hereby release ACTS, Inc. from liability which may arise as a result of information disclosed under this authorization if such information is later used to my detriment.

Signature of Patient/Guardian/Representative (circle one):_____ **Date:**_____

Signature of Patient's Legal Representative (if applicable):_____ **Date:**_____

If signed by Legal Representative, Relationship to the patient: _____

Proper documentation establishing relationship is provided (specify documentation): _____

Signature of Witness: _____ **Date:** _____

****** ACTS has launched our Patient Portal! You can now easily & securely access some of your treatment information online. To sign up, you will need to provide a valid email address. You will then receive an email to complete the registration process. ******

3450 Buschwood Park Drive Tampa, FL 33618: PHONE: (813) 246-4899; FAX (813) 736-7307; RecordsRequest@actsfl.org