HOPE&HELP
HIV/STI Prevention, Testing, & Treatment Services

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# RELEASE OF MEDICAL INFORMATION

UPDATED: 2/24/2020

| Patient Name: | | Date of Birth: | |
|---|---|---|---|
| Address: | City: | State: | Zip: |

**Authorizes the Release of Protected Health Information to Hope & Help from:**

| Health Care Provider Name: | Telephone Number: | Fax Number: | |
|---|---|---|---|
| Address: | City: | State: | Zip: |

**Information to be Released:**

□Medical History Examinations/Reports □Laboratory Reports □Entire Record

□Treatments/Tests □Consultations □Immunizations

□Prescriptions □X-ray Reports □Hospital Records/Reports

□Other (Specify): _____

**Purpose of Disclosure (Check All Appropriate Categories):**

□Further Medical Care □Changing Physicians □Other (Specify): _____

**In compliance with State of Florida Statutes, which requires special permissions to release otherwise privileged information, please release records pertaining to (initials required):**

_____HIV/AIDS _____Mental of Psychological Health _____Genetic Diseases/Tests (DNA)

_____STD/STI _____Drug/Alcohol/Substance Abuse _____Other

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or alcohol/drug abuse, and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above or otherwise required by law. The authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form, by sending a written request to Hope & Help's Privacy Officer, and that I have the right to a copy of this authorization form.

| Patient/Parent/Legal Representative (Signature): | | Date of Authorization: |
|---|---|---|
| Translator/Interpreter: | Address: | Phone Number: |
| Relationship to Patient: | Identification Presented: | |