AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize:
□ Guided Life Care Planning Services
□ My provider(s): _____
□ Other: _____

To use and disclose a copy of the specific health information described below regarding:

_____ _____
(Name of individual) (Date of Birth)

_____
(Address of Individual)

_____
(City, State, Zip Code)

Consisting of:
- ✓ History and physical examinations
- ✓ Consultation reports
- ✓ Laboratory reports
- ✓ Operative reports
- ✓ Discharge summary
- ✓ X-ray/Diagnostic images
- ✓ Bioelectric output (i.e., EKG, EEG)
- ✓ Tissue and/or blood specimens
- ✓ Other, specify_____

To: Guided Life Care Planning Services, Attn: Care Management Team
7825 Lithia Pinecrest Rd.
P.O. Box 621
Lithia, FL 33547

For the purpose of: ***Care management and care coordination***

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my **INITIALS** in the applicable space next to the type of information.
_____ HIV/AIDS information
_____ Mental health information
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment, or referral information

Restrictions:
I request the following restrictions to the use or disclosure of my health information:

May discuss treatment, payment, or healthcare operations with the following persons:

- ☐ Spouse
- ☐ Your children
- ☐ Relative
- ☐ Parents
- ☐ Other: _____

This authorization is voluntary, and you may refuse to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services from your usual providers; however, your refusal to sign this authorization will affect your ability to participate in this care coordination project. You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any uses or disclosures already made with your permission cannot be undone.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

I understand that my health information may be shared with health care providers, social workers, nurse case managers, health lawyers, community agencies, and other professionals who have been, are currently, or will be involved in my care in order to better coordinate my care.

I have read this authorization and I understand it.
Unless revoked, this authorization does not expire.

By: _____ Date: _____
(Signature of individual or Legally Authorized Representative)

Description of relationship to individual: _____

FOR OFFICE USE ONLY

[ ] Patient refused to sign the consent form.

[ ] Restrictions were added by the patient (see Restrictions listed above).

[ ] "Consent form" received and reviewed by _____ on (date) _____

[ ] "Consent form" placed in the patient's medical record on (date) _____