FLORIDA DEPARTMENT OF CORRECTIONS

CONSENT AND AUTHORIZATION FOR USE AND DISCLOSURE INSPECTION AND RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize _____
(Name, organization or general designation of program making disclosure)

to disclose to _____
(Name of person(s) or organization(s) and address to which disclosure is to be made)

Purpose of disclosure authorized herein: _____

The undersigned hereby authorizes the inspection and release of copies of my medical records indicated below by the above-named health care facility/medical record custodian only to the above-named entity(ies) or persons or their agents. Indicate all of the records authorized to be inspected/released by **initialing** in the appropriate box(es) below:

INITIAL BELOW FOR RELEASE OF INFORMATION	
	A. Release of all medical records except: any information relating to HIV testing, AIDS and AIDS-related syndromes; psychiatric and psychological information; or alcohol and substance abuse treatment information related to my condition, care, and confinement **(initial box).**
	B. Release of any records regarding HIV testing, AIDS and AIDS-related syndromes relating to my condition, care, and confinement **(initial box).**
	C. Release of any records of psychiatric and psychological information (mental health records) other than psychotherapy notes relating to my conditions, care, and confinement **(initial box).**
	D. Release of all dental records relating to my condition, care and confinement **(initial box).**
	E. Release of any records regarding alcohol and substance abuse treatment relating to my condition, care, and confinement. I understand that my records are protected under the federal regulations governing *Confidentiality of Alcohol and Drug Abuse Patient Records*, 42 C.F.R. Subchapter A, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. As to release of alcohol/substance abuse treatment records, please state the specific information to be released as provided by 42 C.F.R., Subchapter A, Part 2 **(initial box)**:

Name of information -- dates of treatment/programs, etc., if possible

NOTE: IF PSYCHOTHERAPY OR SUBSTANCE ABUSE PROGRESS NOTES ARE THE SUBJECT OF THE RELEASE, OTHER RECORDS CANNOT BE THE SUBJECT OF THE SAME AUTHORIZATION. RELEASE OF PSYCHOTHERAPY OR SUBSTANCE ABUSE PROGRESS NOTES IN ADDITION TO THE RECORDS SPECIFIED ABOVE WILL REQUIRE A SEPARATE AUTHORIZATION (SEE BELOW).

I understand that I may refuse to sign this authorization and my refusal to sign will not affect my access to health care treatment, eligibility for benefits or enrollment, or payment for or coverage of services. I also understand that once my protected health information is disclosed pursuant to this authorization, it may be used and/or redisclosed by the recipient unless the recipient is covered by law which prohibits or limits its use and/or disclosure.

I understand that I may revoke this consent and authorization at any time, provided the revocation is in writing, except to the extent that action has been taken in reliance on it, and that in any event, this consent and authorization shall be effective for 90 days unless I specify a different expiration as follows: _____
(Specification of the date, event, or condition upon which this consent expires) (For example, "end of incarceration" or, "end of supervision," etc.)

In furtherance of this authorization, I (we) do hereby waive all provisions of law and privileges relating to the disclosures hereby authorized. I acknowledge the extent of my authorization of release as to the records and information denoted in paragraphs A, B, C, D and E by **initialing** the appropriate box(es) above.

_____ _____
SIGNATURE OF PATIENT (Guardian or Statutorily Authorized Representative, when required) Date

AUTHORIZATION FOR RELEASE OF PSYCHOTHERAPHY OR SUBSTANCE ABUSE PROGRESS NOTES

I, _____ authorize _____
(Name, organization or general designation of program making disclosure)

to disclose to _____
(Name of person(s) or organization(s) and address to which disclosure is to be made)

FLORIDA DEPARTMENT OF CORRECTIONS

CONSENT AND AUTHORIZATION FOR USE AND DISCLOSURE INSPECTION AND RELEASE OF CONFIDENTIAL INFORMATION

Purpose of disclosure authorized herein: _____

The undersigned hereby authorizes the inspection and release of copies of my psychotherapy progress notes and/or my substance abuse progress notes as indicated below by the above-named health care facility/medical record custodian only to the above-named entity(ies) or persons or their agents. Indicate all of the records authorized to be inspected/released by **initialing** in the appropriate box(es) below:

INITIAL BELOW FOR RELEASE OF INFORMATION	
	A. Release psychotherapy progress notes **(initial box)**:
	B. Release substance abuse progress notes **(initial box)**:

Name of information -- dates of treatment/programs, etc., if possible

I understand that I may refuse to sign this authorization and my refusal to sign will not affect my access to health care treatment, eligibility for benefits or enrollment, or payment for or coverage of services. I also understand that once my protected health information is disclosed pursuant to this authorization, it may be used and/or redisclosed by the recipient unless the recipient is covered by law which prohibits or limits its use and/or disclosure.

I understand that I may revoke this consent and authorization at any time, provided the revocation is in writing, except to the extent that action has been taken in reliance on it, and that in any event, this consent and authorization shall be effective for 90 days unless I specify a different expiration as follows: _____

(Specification of the date, event, or condition upon which this consent expires) (For example, "end of incarceration" or "end of supervision," etc.)

In furtherance of this authorization, I (we) do hereby waive all provisions of law and privileges relating to the disclosures hereby authorized. I acknowledge the extent of my authorization of release as to the records and information denoted in paragraphs A and B i**nitialing** the appropriate box(es) above.

_____ _____

SIGNATURE OF PATIENT (or Next of Kin, Guardian or Authorized Representative, when required) Date

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THIS FORM IS REQUIRED TO BE NOTARIZED UNLESS WITNESSED BY A MEMBER OF THE FDC WORKFORCE.

STATE OF _____
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me this day of _____, 20_____,
by _____ who is personally known to me or who has produced _____as identification.

_____
Notary Public Signature
Print, type, or stamp commissioned name of Notary Public
My Commission Expires: SEAL

ACKNOWLEDGEMENT OF RECEIPT OF COPY OF SIGNED AUTHORIZATION(S)

Inmate/Offender Name _____
DC# _____
R/S _____
Date of Birth _____
Institution/Office_____

Witness Name _____
Witness Signature _____
Date:_____