

AUTHORIZATION to Use or Disclose Protected Health Information for Marketing, Fundraising, Publication, or Public Relations

| | | | |
|------------------------------|---------|----------------------|--|
| Participant's Name | | Date of Birth | Verification of Identity (Driver's License, ID Card, Passport, etc.) |
| Participant's Address | | | |
| Phone # | Phone # | Email Address | Health Record Number |

**** Complete the following only if the person authorizing the use or disclosure is not the patient:**

| | | | |
|--------------------------|---------------|--------------------------|---------------------------|
| Representative's Name | | Relationship to Patient | Legal Authority |
| Representative's Address | | Verification of Identity | Verification of Authority |
| Phone # | Email Address | | |

By signing this form, I authorize the following:

| | | |
|--|--|-----------------------|
| | The PHI may be <u>used by</u> or <u>disclosed to</u>: | |
| | Person, class of persons, or organization UF CDE | |
| | Address P.O. Box 100417 | |
| | Gainesville, FL 32610-0417 | |
| | Attn: Michelle Hopkins | Phone 352-273-8480 |

The following protected health information may be disclosed: Check all that apply:

My Name
 Address
 Diagnosis
 Treatments
 Prognosis
 Photograph(s)
 Physician or care-giver's name and specialty
 Treating Department or Clinic
 Testimonial(s)
 Other: _____

I further authorize the disclosure of the following information which may be included in the protected health information listed above. (Check all that are approved.)

Mental Health
 Substance Abuse
 HIV/AIDS

This Health Information is being used or disclosed for: Check all that apply:

Marketing Activities
 Fundraising/Promotional Activities
 Public Relations Activities X
 Educational Purposes Outside of UF
 Other: _____

I understand that, by federal law, the University of Florida may not use or disclose protected health information without authorization except as provided in the University's Notice of Privacy Practices. By signing this Authorization, I am giving permission for the uses and disclosures of the described protected health information. I hereby release the University of Florida and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address it to the person or institution named above. I understand that the revocation will not apply to any actions already taken as a result of this authorization.

I understand that I may refuse to sign this Authorization, and that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

I understand that information disclosed pursuant to this Authorization may no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

I have the right to receive a copy of the Health Information released.

This authorization expires automatically for further uses or disclosures of the above described PHI:

After: 1 Year 2 Years Upon written revocation.

I have read and understand the information in this authorization form.

| | |
|----------------------------------|-------------|
| Signature of Participant: | Date |
|----------------------------------|-------------|