

**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:
 Public Relations Activities
 Marketing Activities
 Fundraising/Promotional Activities
 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
----------------------------------	-------------