UF UNIVERSITY of FLORIDA

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:

[redacted]

The PHI may be **used by** or **disclosed to**:

Person, class of persons, or organization
UF CDE

Address
P.O. Box 100417

Gainesville, FL 32610-0417

Attn: CDE

Phone 352-273-8480

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

X My Name Address Diagnosis Treatments Prognosis X Photograph(s)
X Physician or care-giver's name and specialty Treating Department or Clinic X 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:* X Public Relations Activities X Marketing Activities X 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 X Upon written revocation.

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

Signature of Participant:	*Date*