agency for persons with disabilities
State of Florida

Agency for Persons with Disabilities

Consent to Obtain or Release Confidential Information

Individuals Name:		Date of Birth

☐ **Permission for Obtaining Record Information**. I hereby give my permission and consent to the Agency for Persons with Disabilities or its representative to obtain the specified protected health information on the above named consumer from agencies, individuals and institutions identified below OR

☐ **I hereby request the specified protected health information on the above named consumer be sent to me OR**

☐ **Permission for Release of Information**. I hereby give my permission for the Agency for Persons with Disabilities or its representative to discuss matters related to my services or goals or to release protected health information to the following person, agency or institution.

The information requested below will be used/disclosed for the following purposes:

	Medical Reports		Social Service Reports
	Academic Records and Plans		Speech and Hearing Reports
	Habilitation Plans/Support Plans		Physical Therapy Reports
	Psychological Reports		Occupational Therapy Reports
	Other (Please specify):		

Name, address, or fax # of individual or agency from whom information is to be obtained:

Name, address, or fax # of individuals or agencies to whom information is to be provided:

1. **I understand that information may only be re-released with my approval except as required by law. However, I understand that if the receiver of the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.**
2. **I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain services or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.**
3. **I understand that I may revoke this authorization in writing at any time by contacting my support coordinator, except when the requested information has already been sent, based on this authorization.**
4. **I certify that I understand the above statements either personally or through my legal representative.**
5. **I also understand that this form is valid for no longer than 90 calendar days unless otherwise indicated. I understand that I may specify that it be for a shorter period of time.**

Expiration date: _____

Signature of Client or Legal Representative | **Printed Name/Relationship to client** | **Date**

If this authorization has been signed by a personal representative (above) on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here: