Epilepsy Association
109 North Kirkman Road, Orlando, FL 32811
Telephone: 407-422-1416

AUTHORIZATION FOR NONROUTINE DISCLOSURE OF PROTECTED HEALTH INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: _____ Phone: _____

Address: _____ Fax: _____

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: **EPILEPSY ASSOCIATION OF CENTRAL FLORIDA** Phone: **407-422-1416**

Address: **109 NORTH KIRKMAN ROAD, ORLANDO FLORIDA 32811** Fax: **855.376.5016**

INFORMATION TO BE DISCLOSED: (Initial Selection)

_____ General Medical Records(s)
_____ History and Physical Results
_____ Progress Notes
_____ Immunizations
_____ Prenatal Records
_____ Consultations

_____ Diagnostic Test Reports (Specify Type of test(s) ____EEG ____MRI ____CT-SCAN ____Laboratory Results _____All

_____ Other: (specify) **WHOLE CHART; Neurological, MRI. EEG, CT, Seizures, Blood Levels, Lab Work**

I specifically consent to release information relating to: (initial selection)

_____STD _____HIV/AIDS _____TB _____Drug/Alcohol _____Mental Health _____WIC Eligibility _____Early Intervention

PURPOSE OF DISCLOSURE:

_____Continuity of Care _____Personal Use ____Other (specify) **Medical Records**

EXPIRATION DATE: This authorization will expire (insert date or event)_____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and hat I must present my revocation to the medical record department. I understand that the revocation will not apply to information that already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

_____ Client/Representative Signature

_____ Date

_____ Client/Guardian Signature Printed Name

_____ Client/Guardian Signature Relationship

Client Name:_____

Client #:_____

DOB:_____