



RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

Authorization for the Use and Disclosure of Protected Health Information

Federal law states that we cannot share an individual's health information without the individual's permission, except in certain situations. By signing this form, you are giving us permission to share the information you indicate below. If you decide later that you do not want us to share this information any more, you can revoke this authorization at any time in writing or sign the REVOCATION SECTION on the back of this form and return it to the Florida Medicaid TPL Recovery Program. This form must be completed and signed by the Medicaid recipient or by an individual who has the authority to act on the Medicaid recipient's behalf (parent of a minor, legal guardian, trustee, power of attorney, personal representative of the estate, grantor of an annuity).

PLEASE COMPLETE THE FOLLOWING SECTIONS

1. Personal Information:

Medicaid Recipient's Name _____ Date of Birth _____

Medicaid ID Number _____ Social Security Number _____

2. I give permission to the Agency for Health Care Administration (AHCA) and its contract representatives to share the health information listed below with the following:

Name of the Law Firm or Law Office _____

Name of the Insurance Company _____

Other RECORDS DEPOSITION SERVICE, INC. PO BOX 5054, SOUTHFIELD, MI 48086-5054 P: 248-357-3330
F: 248-357-3337

3. Indicate the purpose for which the disclosure is to be made:

___ To substantiate Medicaid's lien relating to a lawsuit

___ To substantiate Medicaid's claim against the estate or against a trust account or annuity

Other FOR DISCOVERY BEFORE TRIAL

4. Indicate the information that you want to be disclosed, related to the following (check one):

___ The Medicaid lien *relating to the injury or negligence* charges, for the period beginning with the date of incident.

___ Medicaid's claim against the *estate*.

___ The amount that is due Medicaid from the *trust account*, [Please send a copy of the trust agreement].

___ The amount that is due Medicaid from the *annuity account*, [Please send a copy of the annuity agreement].

Other, [Please be specific]. PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

5. Enter the specific date that you want this authorization to expire: (i.e., one year from date of release) _____

(If you do not enter a date, this authorization will expire in five years.)

I understand that the information described above may be redisclosed by the person or group that I hereby give AHCA and its contract representatives permission to share my information with, and that my information would no longer be protected by the federal privacy regulations. Therefore, I release AHCA, its workforce members, and its contract representatives from all liability arising from the disclosure of my health information pursuant to this agreement. I understand that I may inspect or request copies of any information disclosed by this authorization if AHCA or its contract representatives initiated this request for disclosure. I understand that I may revoke this authorization by notifying AHCA through its contractor representatives, in writing, knowing that previously disclosed information would not be subject to my revocation request. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or eligibility for benefits.

6. Recipient Signature _____ Print Name _____ Date _____

OR

Name of Legal Representative (Print) _____ Relationship _____

Signature of Legal Representative _____ Date _____

* If you are not the individual, but represent the individual, please attach a copy of the legal document that verifies that you are a representative (parent of a minor, legal guardian, trustee, power of attorney, personal representative of the estate, grantor of an annuity).

INSTRUCTIONS FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Complete the front of the form and return it to Florida Medicaid TPL Recovery Program, Post Office Box 12188, Tallahassee, Florida 32317-2188, Phone (toll-free) (877) 357-3268 or Fax (844) 845-8352.
2. If the signer is a guardian, has a power of attorney or is an authorized representative, documentation of the representative's authority to act on the individual's behalf must be attached. If an agency has custody of a child and a representative signs the release, include a copy of the custody order.
3. Special kinds of health information have specific laws and rules that have to be followed before that information can be disclosed.

HIV and Sexually Transmitted Diseases (STD): All information about HIV and sexually transmitted diseases is protected under federal and state laws and cannot be disclosed without your written authorization unless otherwise provided in the regulations. To release HIV or STD information, this authorization must include a statement in the Information You Want Disclosed section of the specific HIV or STD information that you are giving permission to release. Re-disclosure of HIV information is not allowed, except in compliance with law or with your written permission.

Alcohol and Drug Treatment: Alcohol and/or drug treatment records are protected under federal and state laws and regulations and cannot be disclosed without your written authorization, unless otherwise provided for in federal and state laws or regulations. To release alcohol and drug treatment information, this authorization must include a statement in the Information You Want Disclosed section of the specific information that you are giving permission to release, such as "assessment, treatment plan, attendance, discharge plan." Re-disclosure of you alcohol and/or drug treatment records is not allowed, except in compliance with law or with your written permission.

Mental Health Treatment: Mental health treatment records are protected under federal and state laws and regulations and cannot be disclosed without your written authorization, unless otherwise allowed in federal and state laws or regulations. To release mental health treatment information, this authorization must include a statement in the Information You Want Disclosed section of the specific information that you are giving permission to release, such as "assessment, treatment plan, attendance, discharge plan." Also, disclosure of your therapist's own notes (psychotherapy notes) needs separate permission. Re-disclosure of your mental health treatment records is prohibited, except in compliance with law or with your written permission.

4. You will be provided with a copy of this form.

REVOCATION SECTION

To revoke your authorization, complete the following section and return the form to the Florida Medicaid TPL Recovery Program at the address given above. (Use of this form to revoke your authorization is optional; however, you must submit your revocation request in writing.)

I no longer want my information shared.

Name _____ Date of Birth _____

Street Address _____

City _____ State _____ Zip _____

If applicable, your Medicaid ID number _____

Signature _____ Date _____

OR

Signature of Authorized Representative _____ Date _____

Relationship of Authorized Representative _____