Public Safety Department
EMS Billing
P. O. Box 1000
Bradenton, FL 34206-1000
Phone: (941) 749-3500
www.mymanatee.org

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS TO A THIRD PARTY

Please provide the following information about the person ("Patient") whose records are requested to be disclosed:

PATIENT'S NAME:

_____

PATIENT'S BIRTHDATE: ___/___/____

PATIENT'S DRIVER'S LICENSE OR IDENTIFICATION NUMBER:

DATE(S) OF TREATMENT: ___/___/____ to ___/___/ ____

I, or my authorized representative, hereby authorize Manatee County to disclose specific health information regarding my care and treatment to the following person(s), group or entity ("Agency"):

_____

AGENCY ADDRESS:

_____ _____
_____ _____
_____ _____

Describe the medical records or type(s) of medical information Manatee County has the authority to disclose to the Agency or Agencies identified above:

_____
_____
_____
_____
_____
_____
_____

LOCATION OF CARE (check all that apply to this request):

__Community Paramedic Program
__Emergency Medical Services
__Manatee County Health Care Program
__Health Information Exchange
__Indigent Health Solutions

This authorization may include information relating to **ALCOHOL AND DRUG ABUSE, MENTAL HEALTH TREATMENT** (except psychotherapy notes), and **CONFIDENTIAL HIV/AIDS/STD RELATED INFORMATION** only if I check the box(es) below:

____Alcohol/Drug Treatment
____Mental Health Information (except psychotherapy notes)
____HIV/AIDS/STD Related Information

This authorization for release of Patient's medical records covers the period of health care from ____/___/___ to ___/___/____.

PURPOSE OF RELEASE (Check Reason):
___Request of individual/Personal Rep.
___Continuation of Care
___Insurance
___Attorney/Legal

Other:
_____
_____

FORMAT (Check Requested Method of Delivery): ____ Electronic ___ Paper copy

METHOD OF DELIVERY
__ Mail (insert address):
_____
_____
_____

__ Pick Up
__ Fax: _____
__ Email: _____

This authorization for release of Patient's medical records shall be in force and effect until _____/____/_____, at which time this authorization shall expire.

I understand that I am giving Manatee County permission to disclose the information described above and that this information is no longer protected and may be subject to re-disclosure by the Agency.

I understand that I may revoke this authorization by submitting a Revocation of HIPAA Authorization Form to Manatee County with the understanding that previously disclosed information would not be subject to my revocation request.

I understand that signing this authorization form is voluntary. 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 for health care services or eligibility for benefits.

I understand that if I have questions regarding Manatee County's privacy policies I may direct them to Manatee County Government Attn: HIPAA Privacy Officer, PO Box 1000, Bradenton, FL 34206.

PATIENT'S SIGNATURE: _____

Date: ____/___/_____

If the requestor of the Patient's medical records is a legal representative, guardian, health care surrogate or has the power of attorney, please provide the following information and review the back of this form for the required documentation proving your legal authority to request this information:

Name of Requestor: _____

Representative Capacity: _____

Requestor's Driver's License Number: _____

Address (if not the Patient):

_____

_____

Telephone (if not the Patient)_____

Instructions for Request for Medical Records:

A. If you are a legal representative of the person whose information you are requesting, you must provide the following documentation to prove your legal authority:

1. The records of a decedent - complete the information form on the reverse side. Provide a certified copy of the court order of your appointment as Personal Representative or Executor of the Estate, or a copy of the death certificate noting you as the next of kin or informant.

2. The records of an incompetent - complete the information form on the reverse side. Provide a certified copy of the court order of your appointment as Legal Guardian, Attorney ad Litem or Medical Power of Attorney.

3. The records of a minor - complete the information form on the reverse side. Provide a certified copy of the court order of Guardianship or a copy of a Birth Certificate showing you as natural parent of the minor.

4. Another person's records - complete the information form on the reverse side. Provide a notarized copy of general Power of Attorney or a Durable Power of Attorney for that person.

5. In all requests requiring a court document, the Clerk of the Court's file stamp and the stamped Official Book and Page number on the court order may be accepted in place of a certified copy.

B. Certain types of health information have specific laws and rules that must be followed before that information may be disclosed:

1. **HIV/AIDS and Sexually Transmitted Diseases (STD)**: All information about HIV/AIDS and sexually transmitted diseases is protected under Federal and Florida law and cannot be disclosed without your written authorization unless otherwise provided in the regulations. To release HIV/AIDS or STD information, this authorization must include a statement of the specific HIV/AIDS or STD information you are giving Manatee County permission to disclose. Redisclosure of HIV/AIDS information is not allowed except in compliance with law or with your written permission.

2. **Alcohol or Drug Treatment**: Alcohol and/or drug treatment records are protected under Federal and Florida law 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/or drug treatment information, this authorization must include a statement of the specific information that you are giving MANATEE COUNTY permission to disclose (for example, “For the purposes of my assessment, treatment plan, attendance, or discharge plan.”) Redisclosure of your alcohol and/or drug treatment records is not allowed except in compliance with law or with your written permission (see 45 C.F.R. Part 2).

3. **Mental Health Treatment**: Mental health treatment records are protected under Federal and Florida law and regulations and cannot be disclosed without the patient’s or the patient’s guardian written authorization unless otherwise allowed in Federal or Florida laws or regulations. To release mental health treatment information, this authorization must include a statement of the specific information that you are giving MANATEE COUNTY permission to disclose (for example, “For the purposes of my assessment, treatment plan, attendance, or discharge plan.”) Disclosure of your psychotherapist’s notes needs separate written permission. Redisclosure of your mental health treatment records is not allowed except in compliance with the law or with your written permission.

****All requests require an original signature and a clear copy of the requestor’s photo ID.**

If desiring to pick up these records in person, please call (941) 744-3981 for further assistance.