NOVA SOUTHEASTERN UNIVERSITY | NSU Florida

| Date Received – Official Use Only |
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**Brief Therapy Institute**

**Authorization for Use or Disclosure of Health Information**

| Patient Name (Last, First, Middle Initial): | | |
|---|---|---|
| Patient Address: | | |
| City | State: | Zip Code: |
| Telephone #: | Date of Birth | |

**I authorize release/disclosure of the patient's health records and information**:

| **From** the health care provider, physician, office, facility as listed below: | **To** the patient, personal representative, health care provider, physician, office, facility as listed below: |
|---|---|
| Name: | Name: |
| Address/City/State/Zip: | Address/City/State/Zip: |
| Telephone #: | Telephone #: |
| Health Care Provider Fax # (if applicable): | Health Care Provider Fax # (if applicable): |
| Attention: | Attention: |

**I authorize release/disclosure of the following health information during the term of this Authorization: (*Check all that applies):***

☐ Specific Date of Service ___/___/___
☐ Specific Date Range ___/___/___ to ___/___/___
☐ Billing Records (Specify date or date range) ____________________
☐ Hospitalization (H & P, Consult, Tests, Surgical, Discharge Summary)
☐ Therapy Notes (Specify: PT, OT, Speech, etc.) ____________________
☐ Other ____________________

**The purpose of the disclosure is: (*Check all that applies):***

☐ Continuation of Care
☐ Legal
☐ Personal Reasons (at the request of the individual)
☐ Other ____________________

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse. State and federal law protect the following information. If this information applies to you, please indicate if you further authorize the disclosure of the following information, which may be included in the health information listed above.

**(The following must be separately initialed by you if applicable to your authorization. Initial all that applies):**

| ☐ STD /HIV/ AIDS | ☐ Alcohol, Drug, or Substance Abuse | ☐ Mental Health | ☐ Genetic Data | ☐ Records created by non-NSU providers |
|---|---|---|---|---|
| | | | | |

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

| **Receiving Party Format** | **Method of Delivery** |
|---|---|
| ☐ On Paper | ☐ Mail<br>☐ Pick Up |

**Expiration of Authorization:**

This authorization will remain in force and effect under the following conditions: (*check one preference*)

☐ From the date of this Authorization until the following date: ____/_____/_____

☐ Until the happening of the following expiration event: ________________________________________________

If I do not specify an expiration date or event, then this Authorization will expire ninety (90) days from the date on which I sign the Authorization.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to:

Francesca Angiuli
Nova Southeastern University
Brief Therapy Institute
College of Arts, Humanities and Social Sciences
3301 College Avenue
Fort Lauderdale-Davie, Florida 33314

- I understand my revocation will not apply to information already retained, used or disclosed in response to this Authorization.
- I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand that the clinic will not condition my treatment on whether I provide authorization for the requested use or disclosure.
- I understand that I have the right to:
  - Inspect or copy my health information to be used or disclosed as permitted under state law.
  - Refuse to sign this authorization.

I certify that this form has been fully explained to me, that I have read it or had it read to me, and that I understand its contents.

_________________________________________ _______________________________
Signature of Patient or Personal Representative Date

_________________________________________ _______________________________
Print Name of Patient or Personal Representative Description of Personal Representative's Authority

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**Official Use Only**

Completed by: __________________________________________________ (Print Full Name) Date completed: ___________

Delivery method: ☐ FAXED TO HEALTHCARE PROVIDER ☐ MAILED ☐ IN PERSON

**File in Patient Chart**

Date: April 2003 Revision: December 2007; November 2018