UF UNIVERSITY of FLORIDA

AUTHORIZATION to Use or Disclose Protected Health Information (PHI) via ELECTRONIC MEANS

Patient Name		*Verification of Identity (Driver's License, ID Card, Passport, etc.)*	
Address		Last Four Digits SSN:	*Date of Birth*
Phone #	*Phone #*	*E-mail Address*	*Health Record Number*

** Complete the following only if the person authorizing the use or disclosure is not the patient. **

Name of Representative	*Relationship to Patient*	*Verification of Identity*	*Verification of Authority*
Representative's Address	*Phone #:*	*E-mail Address:*	

See the UF Policy for Verification of Identity and Authority and Personal Representatives in the Operational Guidelines.

By signing this form, I authorize: *(Person or Organization)*

Name: *UF Mobile Outreach Clinic* _____

to communicate with me and with other health care providers, as necessary for: *(check one or both)*

- ☑ my/the patient's healthcare and treatment
- ☑ educational or training purposes,

This communication will take place:

- ☐ one time on *(Date)*: _____
- ☑ on multiple dates.

This communication will take place via:

- ☑ **E-mail**
- ☑ **Video-conference*** Location *ZOOM* _____
- ☑ **Audio-conference*** Location: *Telephone* _____
- ☑ **Other Electronic Means*:** *(Describe)* _____

_____

* _____ *(Enter your initials)* Information about the purpose of the communication(s) and about the communication devices and how they work has been given to me, and I have had an opportunity to ask questions before the communication begins.

Now read each paragraph and check the corresponding checkboxes:

☑ I give permission for my personal health information, which may result from these communications, to be used, disclosed, and retained by the health care providers as needed for my ongoing medical care.

☑ (Video-conference only) In addition, I give permission for the following types of protected health information to be used, disclosed, and retained as described above:

- ☑ Video recordings (sound and picture) of parts of my body that may include my face.
- ☑ Video or electronic displays of X-ray images, Laboratory Test results, Pathology reports and other diagnostic test results.

I further authorize the disclosure of the following types of information that may be included in the PHI listed above. *(Check all that are approved.)* ☑ **Mental Health** ☑ **Substance Abuse** ☑ **STD/HIV/AIDS** ☑ **Genetic Data**

- I have read the Alert for Electronic Communications and agree that the electronic communications described above may include protected health information (PHI) about me / the patient, when necessary.
- I understand that, by federal law, the University of Florida (UF) may not use or disclose my health information without my authorization, except as provided in UF's Notice of Privacy Practices. My signature on this Authorization indicates that I am giving permission for the use or disclosure of the PHI described above. I hereby release UF and its employees from any and all liability that may arise from the release of information as I have directed.
- I understand that I have the right to revoke this Authorization at any time if I do so in writing and address it to the person or institution named above. The revocation will not apply to any information already released as a result of this authorization.
- I understand that I may refuse to sign this Authorization, and that I cannot be denied or refused treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.
- I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be re-disclosed by the person or agency that receives it.

This authorization expires automatically in one year from the date of signing, or upon: ☑ **My written revocation**

☐ **Another Date or Event:** *(Describe)*

Signature of Patient or Legal Representative:	*Date*

Print out this form, complete all parts and sign and date it. The patient/representative should keep a copy. Give, fax, e-mail, or mail the original form to the person who is arranging the electronic communications or with whom the patient will be e-mailing.