AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

You May Refuse to Sign This Authorization

I, _____, (hereafter referred to as "Individual") hereby authorize Deerfield beach Municipal Firefighters' Pension Plan, (hereafter collectively referred to as "you") to use and disclose in any form or format a copy of records concerning Individual but only as follows, to:

City of Deerfield Beach

I specifically authorize you to use and disclose the following types of super-confidential information (initial where appropriate):

_____ HIV records (including HIV test results) and sexually transmissible diseases
_____ Alcohol and substance abuse diagnosis and treatment records
_____ Psychotherapy records
_____ Tuberculosis
_____ All hospital records
_____ All of the above

I specifically authorize you to use and disclose the following Protected Health Information. Please initial one or more of the following, if applicable:

Written Medical records
_____ X-rays/MRI/CT
_____ Billing records
_____ Prescription records
Other (specify in detail) _____.
_____ All of the above

I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this Authorization remains effective until the following date: _____; the following event: _____; or until you actually receive a signed revocation or until the records retention period required under federal and Florida law has expired, whichever first occurs; that I have been given an opportunity to ask questions; that I have received a copy of the signed Authorization; that I may inspect a copy of my protected health information to be used or disclosed under this Authorization; that you have not conditioned provision of services to or treatment of me upon receipt of this signed Authorization; and that I may refuse to sign this Authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided on this form. If the purpose of this Authorization is for the use and/or disclosure of health information for a research study, and I refuse to sign this Authorization, you reserve the right to deny treatment associated with such research. If the purpose of this Authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this Authorization, you reserve the right to deny that health care. I understand that I may inspect or copy the information that is used or disclosed. I understand that I may revoke this Authorization at any time by notifying you in writing, except to the extent that action has been taken in reliance on this Authorization; or if this Authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

A copy of this signed form will be provided the individual.

By Patient: _____ Date: _____
(Print name and sign
Or
By Patient's Representative: _____ Date: _____
(Print name, sign, and describe authority below)

_____

_____