Hallandale Beach
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Human Services Department

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Commissioner

ANTHONY SANDERS
Commissioner

750 N.W. 8th Avenue
Hallandale Beach, FL 33009
Ph (954) 457-1460
Fax (954) 457-1305

www.coHB.org

HUMAN SERVICES DEPARTMENT

HIPAA PRIVACY RULES

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

(Pursuant to 45 C.F.R. Parts 164.502 and 164.508)

1. Specific Description of Information Requested to be Disclosed (specify names and dates of actual medical records/reports to be disclosed, if know; otherwise, indicate records/reports by type:_____

_____

_____

2. Name(s) of the Person(s) {Covered Entity} Authorized to Make the Requested Disclosure (that is, the health plan, health care clearinghouse or health care provider required to obtain this authorization as a "covered entity"):_____

_____

_____

_____

3. Person(s) To Whom Covered Entity May Make the Requested Disclosure: The following named Staff Member(s) of the **City of Hallandale, Human Services Department**, a Florida municipality:_____

_____

_____

4. Expiration Date or Expiration Event that Relates to the Purpose or Use of the Requested Disclosure: unless previously revoked pursuant to paragraph 5 of this authorization, this authorization will expire upon the completion of the client services being handled by the City of Hallandale Beach, Human Services Department for the individual signing this authorization form (but not earlier than one year from the date of this authorization).

5. Right to Revoke this Authorization. The individual signing this authorization shall have the right to revoke this authorization at any time by delivering a written statement to the person(s) named in paragraphs 2 and 3 above (with a photocopy of this authorization attached), specifically stating that such individual revokes this authorization. Such revocation shall be effective upon the delivery of such written statement to such person(s). However, no such revocation shall affect the validity or effectiveness of this authorization (or any action taken pursuant hereto) prior to the effectiveness of such revocation, and the person(s) named in paragraphs 2 and 3 above shall be fully protected in acting upon the authority contained in this authorization prior to their actual receipt of a copy of a revocation statement complying with the terms of this paragraph 5.

6. Re-disclosure of Disclosed Protected Health Information. By his or her signature hereto, the individual signing this authorization form understands that the person(s) named in paragraph 3 above have the right to re-disclose the protected health information received by such person(s) pursuant to this authorization, and hereby consents to such re-disclosure. Such individual also understands and acknowledges that any of the protected health information so disclosed will lose the privacy protection afforded such information by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and in particular 42 U.S.C. 1320d-2, and the regulations promulgated by the Secretary of Health and Human Services under said section (45 C.F.R. part 164).

Dated:_____, 20____ .

_____
Signature of Patient/Client

_____
Print Name of Patient/Client

_____
Witness

_____ /_____
Date of Birth / Social Security Number

HSD-ADM-10 EFF. 08/04