UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT & QUALITY OF CARE

PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW

Patient (Name and information of person whose health information is being disclosed)

Name: (First, Middle, Last):_____

Date of Birth: (mm/dd/yyyy):_____

Address:_____City:_____State: _____Zip:_____

You may use this form to allow your healthcare provider to see and obtain access to your health information. Your choice on whether to sign this form will not affect your ability to get medical care or health Insurance coverage and cannot be used as the basis for denial of health services.

By signing this form, I voluntarily authorize and give my permission and allow disclosure:

OF What: **ALL HEALTH INFORMATION including any information about sensitive conditions** (if any)
(See page 2 for details)
FROM WHOM: ALL information sources (See page 2 for details)

_____ _____
FACILITY/PROVIDER NAME FAX NUMBER

TO WHOM: Specific person (s) or organization(s) permitted to receive my information (must be a healthcare provider):

OLAYINKA A BANKOLE MD PHONE: 813-414-0825 FAX: 813-414-0175
4513 N ARMENIA AVENUE
TAMPA, FL 33603

PURPOSE: To provide me with medical treatment and related services, and to evaluate and Improve patient safety and the quality of medical care provided to all patients.
EFFECTIVE PERIOD: This authorization/permission form will remain in effect until the ***earlier of: my death or the day I withdraw my permission.***
WITHDRAWING MY PERMISSION: I can withdraw my permission at any time by giving written notice to the person or organization named above In "To Whom".

In Addition:
I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
I understand that there are some circumstances in which this information may be redisclosed to other persons (See page 2 for details).
I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.
I have read both pages of this form and agree to the disclosures above from the types of sources listed.

_____ _____
Signature of Patient or Patient's Legal Representative Date Signed (mm/dd/yyyy)

_____
Print Name of Legal Representative (if applicable)
Check one to describe the relationship of Legal Representative to Patient (If applicable):

___ Parent of Minor
____Guardian
____Other personal representative (explain:_____)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Explanation of Form Florida AHCA FC4200-004

"Universal Patient Authorization for Full Disclosure of Health information for Treatment & Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of What": includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:
    a. Drug, alcohol, or substance abuse
    b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CRR 164.501)
    c. Sickle cell anemia
    d. Birth control and family planning
    e. Records which may indicate the presence of a communicable disease or non-communicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
    f. Genetic (Inherited) diseases or tests
2. Copies of educational tests or evaluations, including individualized Educational Programs, assessments, psychological and speech evaluations, Immunizations, recorded health information (such as height, weight), and information about injuries or treatment.
3. Information created before or after the date of this form.

"**From Whom**": includes**: All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, Physicians, psychologists, etc) Including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc), social workers, rehabilitation counselors, Insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers in the "TO WHOM" section, your permission would also Include physicians, other healthcare providers (such as Nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic Interchange.

"Purpose": Your Signature on this form does NOT allow health Insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health Insurers use.

"Withdrawal": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of Information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure. In accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

"Limitations of this Form": If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), Instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/ organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.

Note to recipient(s) of the information disclosed under this permission: This information may have been disclosed to you from records protected by state and/or federal confidentiality rules (42 CFR Part 2 or 38 CFR Part I). If so, the state and/or federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by state law and/or 42 CFR Part 2(e.g. ,certain medical emergencies) or 38 CFR Part1. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient or patient with sickle cell anemia of HIV Infection.

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under 45 CFR Parts 160 and 164 (HIPPA); Health information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division D of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009) 13405 ("HITECH Act"); 42 U.S. Code 290dd-2;42 CFR Part 2; 38 U.S. Code section 7332;38 CFR 1.475 (Veterans Affairs); 20 U.S. Code 1232g ("FERPA"); 34 CFR parts 99 and 300; 42 CFR 59.11 (Family Planning); Florida Statute 408.051 (4) ("Universal Patient Authorization Form"); and all other Florida Statutes, the Florida Constitution, Florida regulations or administrative rules requiring patient authorization, consent or permission to release such records (including but not limited to Florida Statutes 456.057 (7) (a), 395.3025 (4), 394.4615(2) (a), 381.004, 397.501(7), 760.40(2), 392.65(1), and 385.202(3).