SEMINOLE COUNTY SHERIFF'S OFFICE JOHN E. POLK CORRECTIONAL FACILITY
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION/RECORDS

THIS FORM IS REQUIRED TO BE NOTARIZED IF PATIENT AUTHORITY AND CONSENT CANNOT BE PROPERLY VERIFIED

Request can be provided by personal delivery or mail to the John E. Polk Correctional Facility, 211 Eslinger Way, Sanford, FL 32773 or by Fax to (407) 665-1236 or via email to inmatemedicalrecords@seminolesheriff.org.

I, _____ **DOB:** _____ **SS#:** _____ **Phone Number:** _____

authorize the John E. Polk Correctional Facility- Seminole County Sheriff's Office and its employees and agents to release copies of my Confidential or Protected Health Information, ("PHI"), to the following individual, healthcare provider, entity or agency:

Provide Name(s) and address of individual, healthcare provider, entity or agency to receive the Confidential or PHI. INCLUDE HOW THE INFORMATION IS TO BE RELEASED FOR EXAMPLE, MAIL, EMAIL, PICK UP. The agency is not responsible for the release of records to the person, entity or provider indicated or the manner of release the patient indicates.

_____

For the purpose of: _____

(A statement "at the request of the individual" is sufficient if the client signs this Authorization and does not wish to give a specific reason.)

INITIAL BELOW FOR RELEASE OF INFORMATION AND PROVIDE DATE RANGE	
	A. Release of all medical records **except:** any information relating to HIV testing, AIDS and AIDS-related syndromes; psychiatric and psychological information; or alcohol and substance abuse treatment information related to my condition, care, and confinement. **(initial box).** Release will include Patient History; Physical, Prenatal if applicable, Progress notes and Diagnostic results of Lab/x-rays, diagnosis and treatment unless you indicate otherwise. **DATE RANGE:**

I understand documentation originated at the John E. Polk Correctional Facility- Seminole County Sheriff's Office may contain information or records regarding medical history that may be considered Super Confidential. I further understand that this type of information must be separately authorized by initialing separately below. By not initialing below, the John E. Polk Correctional Facility - Seminole County Sheriff's Office cannot provide this additional information.

INITIAL BELOW IN BOX FOR RELEASE OF THIS ADDITIONAL INFORMATION AND PROVIDE DATE RANGE	
	B. Release of any records regarding HIV testing, AIDS and AIDS-related syndromes relating to my condition, care, and confinement (initial box). **DATE RANGE:**
	C. Release of any records of psychiatric and psychological information (mental health records) other than psychotherapy notes relating to my conditions, care, and confinement (initial box). **DATE RANGE:**
	D. Release of all dental records relating to my condition, care and confinement (initial box). **DATE RANGE:**
	E. Release of any records regarding alcohol and substance abuse treatment relating to my condition, care, and confinement. (initial box): **DATE RANGE:**

I understand that this Authorization may be revoked upon written notice, except to the extent that action has already been taken in reliance on this Authorization. Any revocation of Authorization can be provided by personal delivery or mail to the John E. Polk Correctional Facility, 211 Eslinger Way, Sanford, FL 32773 or by Fax to (407) 665-1236 or via email to inmatemedicalrecords@seminolesheriff.org. Please include the date the Authorization was signed. **This Authorization will expire one year from today's date unless another expiration date or event is indicated.** Date of Authorization Expiration: _____

I understand that this authorization is voluntary and that I may refuse to sign it. I further understand that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria. I also understand that once my protected health information is disclosed pursuant to this authorization, it may be used and/or redisclosed by the recipient unless the recipient is covered by law which prohibits or limits its use and/or disclosure.

_____/Authority if not Patient:_____ _____

Signature of Patient (*or Next of Kin, Guardian or Authorized Representative, when required. *May require proof of authority) Date

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STATE OF_____ COUNTY OF_____

The foregoing was sworn to (or affirmed) and subscribed before me this _____ day of _____ 20____ by means of ___ physical presence or ___ on line notarization by

_____ who is _____ personally known or _____ produced identification. Type of identification: _____

Print, type, or stamp commissioned name of Notary Public My Commission Expires:

SEAL

ACKNOWLEDGEMENT OF RECEIPT OF SIGNED AUTHORIZATION(S) (Internal Use Only)

Employee Printed Name:_____ **Employee Signature:** _____ **Request Received Date:** _____

Records Provided Date: _____ **Provided to/Verification:** _____

Verification method if not notarized: _____ **Method of Delivery/Address:** _____

Form Amended August 2022