HIPAA Authorization Form

1.) I _____ (patient/ legal representative) hereby authorize the Public Health Trust of Miami-Dade County, FL ("Trust") doing business as Jackson Health System, and all employees and agents of the Trust, to use and/or disclose the protected health information of _____ (patient name) as described below.

2.) I authorize the following information to be used and/or disclosed:

- Demographic information
- Financial assistance application information

3.) I authorize the Trust to use or disclose the protected health information (as described above) to:

- _____

4.) I understand the purpose of the requested use or disclosure may be used for the following:

- To assist me in my application for financial assistance

5.) I understand this authorization is voluntary and I am under no obligation to sign. The Trust will not alter, withhold, or extend treatment based upon completion or refusal of this authorization.

6.) I understand that I may revoke this authorization at any time by writing to the Jackson Health System's Privacy Officer at 1611 NW 12th Avenue, Miami, Florida, 33136, of my intent to revoke this authorization. I understand that such a revocation will have no effect on information already used or disclosed by the Trust prior to the receipt of my written notice of revocation.

7.) I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient listed above and no longer protected by federal or Florida privacy laws.

8.) I waive any and all present and future claims I may have against the Trust, its staff, employees, agents, affiliates, and Trustees in connection with any exhibition of release of this information by the recipient listed above.

9.) Unless otherwise revoked, I understand that this authorization will be valid ninety (90) days from the date it is signed.

_____

SIGNATURE OF PATIENT, PARENT OR AUTHORIZED LEGAL REPRESENTATIVE/GUARDIAN DATE TIME

_____

PRINTED NAME OF PATIENT, PARENT, OR AUTHORIZED LEGAL REPRESENTATIVE/GUARDIAN

RELATIONSHIP TO PATIENT: ☐ Self ☐ Parent ☐ Patient's Authorized Legal Representative/Guardian ☐ Other

_____

JACKSON HEALTH SYSTEM AUTHORIZED SIGNATURE/WITNESS

Jackson Health System Miami, FL 33136		
	HIPAA Authorization Form	(Affix Patient Label Here)