Mid Florida Counseling, LLC
1400 West Oak Street, Suite G
Kissimmee, FL 34741
Phone: 321-250-1054 • Fax: 321-256-0307
www.mflcounseling.com

HIPAA AUTHORIZATION FORM

Patient's Full Name | **Patient's SSN (last 4) or Medical Record Number**

Address | **Patient's Date of Birth**

City, State Zip Code | **Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:
   Mid Florida Counseling, LLC /
2. The following person (or class of persons) may receive disclosure of protected health information about me:

   His/her/its Name

   Address

   City, State Zip Code
3. The specific information that should be disclosed is:

_____

_____

_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
YES, DISCLOSE THIS INFORMATION * _____

NO, **DO NOT** DISCLOSE THIS INFORMATION * _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying Mid Florida Counseling, LLC in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for _____ .
7. This authorization expires on _____, 20___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.
THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

_____ | _____ | _____
Signature of Individual* | **Date of Individual's Signature** | **Date of Birth or Social Security Number (last 4)**
(The person about whom the information relates)

OR, if applicable –

_____ | _____ | _____
Signature of Guardian* or Patient's Personal Representative | **Date of Guardian's/Personal Representative's Signature** | **Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signator.