VAVA CLINIC

8855 Immokalee Road, Unit 3
Naples, FL 34120
(239) 331-8520 • Fax: (239) 331-8564

Authorization to Use or Disclose Health Information

Patient Name: _____

Social Security Number: _____ Date of Birth: _____

Address:_____

City: _____ State:_____ Zip Code: _____

I hereby authorize VAVA Clinic to release the above medical information to the following individual(s) or organization(s):

_____

_____

This information for which I am authorizing disclosure will be used for the following purpose:

_____

The type of information to be used or disclosed is as follows:

_____HIV (AIDS) test results_____(initials)

I understand that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse. I further agree to release the above named facility, employees, and physicians from all legal responsibility and liability that may arise from the disclosure and/or unauthorized redisclosure of such information. I understand that I have a right to revoke this authorization at any time and that I must do so in writing. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest claim under my policy or to the information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, the authorization will expire in one (1) year from the signature date below. I understand that authorizing the disclosure of this health information is voluntary. I understand that the medical provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

_____ _____

Signature of Patient or Legal Guardian/Representative Date

If signed by Legal Guardian/Representative, relationship to patient_____

_____ _____

Signature of Parent/Guardian Date