UF ADA Office Release of Information Form:
Authorization to Request Protected Health Information (PHI) From Provider

Note: *This form is used to obtain health information from a healthcare provider*

Employee's Name	Date of Birth	Employee UFID Number:
Employee's Address	City State	Zip
Phone #		Verification of Identity:

By signing this form, I authorize and grant permission for the following:

To the Specific Facility/ Provider to share PHI *(enter information about the provider sharing the PHI)*	Person or Facility: Complete Mailing Address: Fax

To share the PHI with UF ADA Office	**UF ADA Office** 720 S.W. 2nd Ave Suite 106 Gainesville, FL 32601 Fax: 352-392-5268 Email: adaservices@ufl.edu Phone: 352-273-3721	**I authorize the PHI to be shared in the following ways:** ☐ Verbal ☐ Email ☐ Fax

What PHI may be shared? (*check all that apply)*		**Date of Service from which PHI may be shared?**
□ Medical Notes/summary	□ Treatment Notes	Dates for services relating to PHI to be shared:
□ Medication List	□ Other:	

Purpose of this request?	☐ Consultation/ADA Accommodation ☐ Consultation/Clarification regarding condition and treatment ☐ Other:

This Authorization allows the designated provider to release certain PHI, which includes information found in medical records, as I have directed above.

I understand that:

- The PHI may include information about mental health, substance use disorder, HIV/AIDS and STDs.
- This authorization may be used to share the same type of PHI indicated above which may be created in the future, until the expiration date.
- This authorization will remain in effect for one (1) year or until I revoke it in writing (ie., tell the ADA Office to cancel it).
- I have the right to revoke this authorization at any time, if I do so in writing to the provider listed above, and that the r evocation will not apply to action already taken as a result of this authorization.
- I may refuse to sign this authorization and doing so will not affect my treatment, payment, enrollment or eligibility for benefits or the quality of care that I receive.
- I understand that PHI released per this authorization may no longer be protected by state law or the federal health privacy law and could be re-disclosed by the person or entity receiving it.

Signature of Employee/employee representative _____ **Date** _____

Complete following section if person making the request is not the patient.

Name of requestor: _____

Relationship to Employee: ☐ Parent ☐ Legal Guardian ☐ Other

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