ESCAMBIA COUNTY JAIL
HEALTH SERVICES SECTION
Release of Information

I , _____, authorize

Escambia County Jail
Name/Organization

2935 N "L" Street
Address

Pensacola, FL 32501
City/State/Zip

850-436-9801
Telephone

850-595-2008
Fax

to disclose to:

_____
Name/Organization

_____
Address

_____
City/State/Zip

_____
Telephone

_____
Fax

the following information:

_____ Medical Progress Notes since _____	_____ Mental Health Records	_____ Medication Administration Record (MARS)
_____ Initial Psychiatric Evaluation	_____ Immunization Record	_____ Psychological Evaluation
_____ Infirmary Records	_____ Pathology Report	_____ Laboratory Reports
_____ Verification of current medication	_____ Radiology Results	_____ Operative/Procedure Report
_____ Verbal Communication	_____ Entire Record	_____ Consultation Reports
_____ Other: _____		

Approximate date(s) of service: _____

The purpose of the disclosure authorized is to: _____

I understand that the information in my health record may include information relating to the sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), Hepatitis B, or Hepatitis C. It may also include information about behavioral or mental health services and treatment for drug and alcohol abuse. I also understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it. This authorization will expire on _____. If I fail to specify and expiration date, this authorization will expire twelve months from the date it was signed.

The Escambia County Jail is required by law to protect my health information. By signing this document, I authorize the Health Services Section at the Escambia County Jail and Emerald Coast Rehab Associates, Incorporated to use and/or disclose/release my health information as described above in the "Purpose of the disclosure" statement. Those persons who receive my health information may not be required by Federal privacy laws (such as the Privacy Rule) to protect it and may share my information with orders without my permission, if permitted by laws governing them.

Date: _____ Patient Signature: _____

Date: _____ Staff Witness Signature: _____

PATIENT NAME:	NO:	D.O.B.	SEX	Facility: