SAMPLE WAIVER OF PRIVILEGE AND CONFIDENTIALITY OF RECORDS OF FUNDED SERVICES
Pursuant to § 381.775, Fla. Stat.

RETURN TO: depcs.bscip@flhealth.gov. Use this Sample or include all the information shown below. Retain the original; the Program is entitled to request the original before releasing records.

I, _____, am the applicant for
(PRINTED full legal name of applicant or recipient – NOT the applicant's/recipient's representative)

or recipient of funded services through the Florida Brain and Spinal Cord Injury Program (Program).

I understand that Program records, information, and communications (records) related to my application for and receipt of funded services are subject to **more strict protection** than health information as described by 45 CFR § 164.502, the Health Insurance Portability and Accountability Act (HIPAA) and § 766.1065, Fla. Stat.; that **I have a privilege** against the disclosure of these records; and **I intentionally waive** my right to confidentiality in these records and authorize the Program to send copies to (check only one box) ☐ me, **OR** ☐ my representative (not an attorney), ☐ my designated licensed health care professional, ☐ my attorney, **OR** ☐ the attorney for another party, or ☐ another entity. **I understand** that transmission by facsimile or email may not be secure and that I assume any risk of inadvertent disclosure if I choose to have my records sent by fax or email.

_____
(PRINT legal name of individual to receive copies and, if applicable, practice or entity name)

_____
(mailing address, telephone, facsimile, email)

This waiver is for ☐ obtaining reimbursement to the Program from a third party ☐ my own use.
I specifically authorize the release of information relating to: ☐ STD ☐ HIV/AIDS ☐ TB ☐ WIC Eligibility ☐ Early Intervention ☐ Drug/Alcohol Abuse ☐ Mental Health.

My representative's relationship to me is ☐ court-appointed legal guardian, ☐ health care surrogate, ☐ natural or adoptive parent of a minor, ☐ trustee, ☐ agent appointed by a power of attorney, or ☐ grantor of an annuity. **My attorney or any payor of third-party benefits is not a representative who can sign on my behalf. The Program may require documentation of my representative's contact information and relationship to me prior to disclosing my protected health information.**

This waiver expires on the earliest of _____, when _____,
(date) (event, i.e., my case is settled)
or 12 months from the date below. I can revoke any time by writing to the address above. Revocation does not apply to information that has already been released.

The Program will not deny funded services or my eligibility for funded services if I do not sign this waiver, but **I understand** that by accepting funded services, I have authorized the Program to release protected health information about those services solely to obtain reimbursement. Illegible entries above this line may void this waiver.

_____ _____
(Signature of Applicant/Recipient or Representative) (date)

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