THE SCHOOL DISTRICT OF ESCAMBIA COUNTY
75 NORTH PACE BOULEVARD
PENSACOLA, FL 32505
PH (850)469-6267 FX (850)469-6107
http://escambiaschools.org
KEITH LEONARD, SUPERINTENDENT

RELEASE OF MEDICAL RECORDS/INFORMATION

I **(Please Print Name)** _____, hereby authorize release of medical information to the Worker's Compensation Adjuster, Escambia County School District, 75 North Pace Boulevard, Pensacola, FL 32505, including reviewing and copying of all hospital, medical and rehabilitation records as well as discussing with my physicians, nurses, and vocational rehabilitation, physical or mental health care providers, my medical diagnosis, treatment, care and prognosis. I further authorize the Worker's Compensation Adjuster to release appropriate medical records to other physicians or medical providers who may be involved in my medical care and rehabilitation and are hereby relieved of any responsibility or liability that may arise from the release or reproduction of such records and/or information in accordance with this authorization. I understand that my Protected Health Information that is used or disclosed under this agreement may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information may no longer be protected by law. **This request is in accordance with 45 CFR 164.512(l), Disclosures for Workers' Compensation Purposes and Florida Statute 440.13.**

_____ I do (or) _____ I do not
authorize the release of information, including, if applicable, specific laboratory tests of HIV Infection (Human Immunodeficiency Virus, the causative agent of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, all medical records or other information regarding my treatment, hospitalization including psychological or psychiatric impairment, drug abuse and/or alcoholism or sickle cell anemia.

A photocopy of this release as signed by me may be used in lieu of any original, and any such photocopy shall have the same validity as if it were an original.

This release shall remain effective for one (1) year from the date indicated below.

I understand that I may revoke this authorization, if the revocation is in writing except if the hospital/facility has taken action in reliance upon this Authorization.

I understand I will be provided a copy of this release upon request.

SIGNATURE:_____ DATE:_____

SS#: XXX-XX-_____ DOB: _____

Please list all treating physicians for the past five (5) years:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____