AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION AND TO PERMIT TESTIMONY BASED UPON HEALTH INFORMATION

PATIENT NAME:

DATE OF BIRTH:

I ____ (Patient Name), authorize the disclosure of the above identified Patient's health information as recited in this authorization.

I hereby authorize ____ (Medical Provider), hereinafter referred to as Medical Provider(s), to release the Patient's entire health information, including, but not limited to, admission and discharge records, medical and billing records, progress notes, flow sheets, medication records, test results, physician orders, consultation records, diagnostic test results and images, videotapes, photographs, notes, call records, pharmacy records, psychiatric and mental health counseling records, substance abuse records (including counseling), information regarding HIV testing, diagnosis and treatment, and any other information contained in a designated record set, and to discuss, provide opinions, conduct conferences and/or provide deposition, trial or other testimony related to the medical treatment of Patient, to The Office of the State Attorney. Hillsborough County hereinafter referred to as Requesting Party.

The purpose for these disclosures is to allow the above referenced Requesting Party to obtain and review Patient's records from Medical Provider(s) and also to allow all Medical Provider(s) who provided care to Patient to discuss and provide opinions and/or testimony, whether via conference, in deposition and/or at hearings or trial, concerning the above referenced Patient. This authorization further permits the above referenced Medical Provider(s) to receive records to review for the purpose of conducting a conference or testifying in any civil, criminal or administrative matter. This Authorization specifically permits all Medical Provider(s) to provide testimony and/or opinions regarding such records and/or medical treatment. This Authorization expires on the date that the pending legal matter *State v.* ______________________________, Hillsborough County Case No. ______________________ is terminated by any means. A copy of this Authorization shall be treated as if it were the original.

I understand I have the right to revoke this authorization in writing by providing a signed, written notice of revocation to the above-named Medical Provider(s) except to the extent that the Medical Provider(s) identified above has taken action in reliance on this authorization.

I am aware that any information that is disclosed to a third party pursuant to this Authorization may be subject to re-disclosure and no longer protected by applicable law.

____ ________________

Signature of patient or personal representative **Date**