HEALTHY FAMILIES FLORIDA

Limited Authorization to Exchange Information

I, LaKirrie Robinson, or my authorized representative, request that my personal and private health information, including records of my care, treatment, and health, be exchanged with the agency/individual initialed below. This includes, but is not limited to the release of intake forms, consults, counseling and home visiting sessions, mentoring, immunizations, medical records, insurance information, applications, and financial information. The purpose of this release is to ensure my family and I receive the best possible services and support. This may include services related to health and safety, financial assistance, child development, and parent education. Unless I give specific written permission on a separate authorization form, Healthy Families staff will not share information related to Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), tuberculosis (TB), sexually transmitted diseases (STDs), alcohol, substance abuse, and mental health treatment. If information being exchanged is for Psychotherapy Notes, a separate authorization form is required

By signing below, I, or my authorized representative, authorize Kim Thomas, staff of Healthy Families Gadsden/Leon located at 20 Ram Blvd., Midway / 1315 Linda Add Dr., Tallahassee, to exchange the following specific information,
Release of Poem written by Participant, for the purpose of
publishing in FSU College of Medicine H.E.A.L. Publication with the following agency/individual:

Alessandra Taylor, MS / Florida State University College of Medicine HEAL Publication
Name of Agency or Person

This information is to be shared in order that I or my family might receive the best services for my/our needs.

- I understand that, without exception, I have the right to cancel this authorization by writing to the Healthy Families address above. However, I understand that any exchange of information that occurred because of this authorization cannot be reversed, and my cancellation will not affect those actions.
- I understand that the agency/individual receiving my information may be required, by subpoena or other lawful act or process, to re-disclose the information and the information would not be protected by HIPAA or other state or federal law.
- I understand that the agency/individual to which this authorization is directed may not base treatment, payment, enrollment or eligibility benefits on whether or not I sign this authorization.
- Any fax or photocopy of the authorization shall have the same force and effect as the original.
- I acknowledge that if I want to add more agencies/individuals to which information may be disclosed, I must complete a new release form.
- This authorization shall take effect on the date below and expire 12 months from that date.

LaKirrie Robinson — Signature of participant or authorized representative

02/11/16 — Date

Nature of representative's authority (parent, guardian, etc.)

☐ Check to indicate a signed copy of this form was given to the participant.