SENSITIVE DATA AUTHORIZATION

I, _____ [printed name], hereby give consent and permission to authorize the exchange of my health and personal information by and among the Children's Trust of Alachua County (the funding organization or "Funder") its partners, the NewboRN Home Visiting Program (NHVP) of the Healthy Start of North Central Florida, Inc.(HSNCF) and other agencies that work together to provide payment, treatment, or other services to me and my children, including the Funder, HSNCF; the evaluator, the University of Florida; and the software providers, GoBeyond, my health plans, and my health care providers (collectively referred to as "Recipient" herein) as needed for the coordination of care I receive through these entities including without limitation for purposes of providing services, improving quality of services, or determining program eligibility.

In agreeing to sign this Consent, I understand:

- Information disclosed pursuant to this Consent may be re-disclosed by the Recipient. Such disclosure may no longer be protected by state or federal confidentiality and privacy laws.
- I may refuse to sign this Consent. Signing this Consent form is voluntary and refusing to sign it will not prohibit you from receiving services from any of the above Recipients. Mark this box if you do not give permission for your health information to be shared with the above Recipients.
- I may revoke this consent at any time, except to the extent that action has already been taken in reliance on this Consent, and I must do so in writing. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer. If Consent is revoked, the Recipients identified above shall not be required to recall information already shared.

I understand certain types of information cannot be released without my specific authorization. By my initials below, I specifically authorize the release of information pertaining to:

_____ Drug, alcohol abuse, diagnosis or treatment
_____ Psychiatric, Psychological or Mental Health diagnosis or treatment
_____ STD, or HIV/AIDS information/ status
_____ Genetic testing information

Expiration Date: This Consent remains in effect until revoked in writing by me.

I have read this Consent before signing and fully understand the contents, meaning and impact. I understand that I am free to address any specific questions and have done so prior to signing this Consent.

Name: _____

Infant Name: _____ Date of Birth or Estimated Due Date: _____

Address: _____

Telephone Number: _____

Email Address: _____

Signature by (select one): [patient] [patient representative/guardian] [staff on behalf of patient whose consent was obtained verbally]: _____ Date: _____