Authorization to Use or Disclose Health Information

Name:_____ Date of Birth:_____

I HEREBY AUTHORIZE the disclosure to and the use of the above named individual's health information as described below.

1. The following individual(s) or organization(s) are authorized to make the disclosure:

Any and all Physicians (including Psychologists/Psychiatrists), Facilities and/or Hospitals who have provided treatment and the City of Lake Worth, FL.

2. The type of information to be used or disclosed is my entire medical/health record.

3. I understand that the information in my medical/health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. The information identified above may be used by or disclosed to:

City of Lake Worth Beach General Employees' Retirement System c/o Sugarman & Susskind, P.A.
100 Miracle Mile, Suite 300
Coral Gables, FL 33134

5. This information for which I'm authorizing disclosure will be used for the following purpose:

To facilitate the Board of Trustees of the City of Lake Worth Beach General Employees' Retirement Syst em in the carrying out its duty to review, discuss and determine my application for disability retirem ent. I hereby waive the right of confidentiality of medical/health records and other medical evidence in the custody of the Board of Trustees or elsewhere. I further understand that such records will be discus sed during one or more public meetings and will become public record. I understand that the Boar d of Trustees will rely upon this waiver.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical/health care provider. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my insurance policy.

7. This authorization will expire eight months from the date on which it was signed.

8. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

9. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

10. I also authorize the use of photocopy of this document in place of the original.

_____ _____

Signature of patient or legal representative Date

If signed by legal representative, relationship to patient:_____

Signature of witness:_____ _____

Date