



FLORIDA PAROLE COMMISSION
Tallahassee, Florida

CONSENT AND AUTHORIZATION FOR
USE, DISCLOSURE, INSPECTION, AND RELEASE OF
CONFIDENTIAL MEDICAL, MENTAL, AND/OR HEALTH INFORMATION
(Related to Seaport Security and Section 311.12(7)(e), Florida Statutes (2009))

NAME (Please print)	RACE	SEX	DATE OF BIRTH	SOCIAL SECURITY #
				XXX-XX-____

I hereby acknowledge that, pursuant to Section 311.12(7)(e), Florida Statutes (2009), I am requesting a waiver of my disqualifying criminal history factors through the Florida Department of Law Enforcement (FDLE), for the purpose of obtaining employment within or unescorted access to secure or restricted areas of one or more Florida public seaports (listed in Section 311.09, F.S.), and that Florida law requires a factual review and investigation by the Florida Parole Commission (FPC) of my application for a waiver and of factors relevant to a determination that I do not pose certain risks specified in the above statute. My application for a waiver request will be referred by FDLE to the FPC for such review and investigation. The FPC will create and forward to FDLE a report of the Commission's factual findings, which will be used by FDLE to make a final disposition of my waiver request. One or more Florida public seaports will apply FDLE's disposition to the seaport(s) determination of whether I will obtain seaport access. I understand that the purpose of this release is to facilitate any investigation that provides for the content of the FPC report to FDLE and to authorize the re-disclosure of information obtained pursuant to this release to FDLE by the FPC and to the Florida public seaports by the FPC, FDLE, and/or other Florida public seaports, for the purpose of determining my access to such seaport(s).

Under the Privacy Act of 1974, Chapter V, Section 552(a)(b), I hereby authorize any criminal justice agency, police department, sheriff's office, Federal or State agency, school or employer, or any person or entity of any kind or character, to make full disclosure and furnish copies of any information in its possession, as to my present situation and my background, including adult and juvenile records.

The undersigned hereby authorizes the inspection and release of copies of the records indicated below, whether such records or information contained therein are confidential, private, or public record, for all periods of treatment, by any and all physicians, hospitals, clinics, public health authorities and others, only to an authorized representative of the FPC, for the factual review and investigation by FPC of my application for a waiver request pursuant to Section 311.12(7)(e), Florida Statutes (2009), for the disposition by FDLE of my waiver request, and for the determination by the Florida public seaports of my access to secure or restricted areas of the seaports.

In accordance with Florida Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- A. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV testing, AIDS and AIDS-related syndromes; only if I place my initials on the appropriate line authorizing disclosure.
- B. The recipient of this information is prohibited from redisclosing such information, except to FDLE and the Florida public seaports, without my written authorization, unless permitted to do so under federal or state law. FDLE is authorized to re-disclose such information to the Florida public seaports. The provider of the information, the FPC, FDLE, and the Florida public seaports are released from any liability for disclosure of the information to the extent indicated and authorized herein or by law.
- C. I have the right to revoke this authorization at any time by a letter to the FPC and FDLE.
- D. I have been provided or I have retained a copy of this signed and notarized authorization.
- E. This authorization will expire upon verified receipt by FPC and FDLE of written notice of revocation from me.

I authorize the recipient of this document to release to an authorized representative of the FPC the following record(s), and the FPC and FDLE to re-disclose such records as provided herein:

(Initial in the blanks below):

___ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, referrals, consults, prescriptions, and records sent to you by other health care providers.

___ Any records of psychiatric and psychological information other than psychotherapy notes.

___ Any records regarding Alcohol and Substance Abuse Treatment. I understand that federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 U.S.C. §290(ee)(2) protect my records and expressly authorize the release of this information by my initials and the signature below.

In furtherance of this authorization, I do hereby waive all provisions of law and privileges relating to the disclosures and re-disclosures hereby authorized. I acknowledge the extent of my authorization of release as to the records and information denoted herein by affixing my signature below.

Signature of Applicant

(or Next of Kin, Guardian or Authorized Representative, when required)

Date

(Applicant acknowledges, by above signature, that they have retained a copy of this signed and notarized authorization.)

Notary Authentication

STATE OF _____

COUNTY OF _____

Personally known _____ OR Produced Identification:

Type of Identification Produced:

Sworn to (or affirmed) and subscribed before me this
_____ day of _____, 20_____.

Notary Public Signature:

Print, type or stamp commissioned name of Notary Public: _____

My Commission Expires: _____

SEAL

