



Self-Directed Solutions

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**AUTHORIZATION FOR RELEASE OF INFORMATION TO DELPHI**

I hereby authorize my health plan, physicians and healthcare providers to release to Delphi of Florida ("Delphi") and their applicable business associates to disclose the following Private Health Information pertaining to me: enrollment, claims, payments, medical records information, including medical history, results of diagnostic exams, therapy, physician notes, and records related to my health for the purpose of assisting me in my quest to obtain health care services and/or approval or payment for health care services.

Unless indicated, my authorization includes the release of the following information (strike through those you wish to exclude, if any), HIV-related, alcohol or drug treatment, genetic test results or mental health treatment information.

I understand that Delphi provides administrative and informational services only and does not provide health insurance or medical services nor does it recommend treatment. Consequently, independent health care practitioners, who are not employees or agent of Delphi, will provide all my medical services.

The information may be released by any physician, medical practitioner, hospital, clinic or medically related facility, related to my medical condition.

A photocopy of this authorization shall be valid as the original.

I understand I may revoke this authorization at any time via written communication to Delphi.

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\_\_\_\_\_  
Patient

\_\_\_\_\_  
Patient/Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name