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AUTHORIZATION TO RELEASE INFORMATION

Patient Name: ______________________________________ Date: _______________

Social Security Number: ________________________ DOB: ___________________

This Will Authorize ____
to release protected health information from my medical record in accordance with Florida Statutes (394.459 (b), 381.609 (2)(F), 90.503, 458.21, 396.112, 397.053, 490.32, 90.42 and Federal Law 42 CFR II).
The release of any information concerning AIDS, HIV, AIDS-Related Complex and the performance of any tests, counseling and the results and treatment thereof are also authorized. I understand that my records have a privileged and confidential status. I am waiving that status for the purpose contained within this authorization.

The Specific Information Requested is:

- ❑ Initial Assessment
- ❑ Treatment Plan
- ❑ Diagnosis
- ❑ Narrative Summary/Reports
- ❑ Drug/Alcohol Treatment
- ❑ Discharge Summary
- ❑ Other: ___________________

This information is to be released to:

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For The Purpose of: <u>Assessment and Treatment Planning; Continuity of Treatment</u>

A general medical authorization and subpoena duces tecum without a specific authorization to release psychiatric information MUST have this waiver from the patient or his/her empowered representative.
I understand that I have the right to refuse to sign this authorization.
I further understand that I am authorizing the release of information from records whose confidentiality and privileged status is protected by Federal Regulations and Florida Statutes; and that any redisclosure of this information by the receiving entity is prohibited.

This authorization is for a _______ single, or ________ continuing disclosure, and is valid for one (1) year after the date of my signature as it appears below. This authorization may be revoked at any time upon written notification by the patient but revocation has no effect on action previously taken.

______________________________________ ______________________________________
Signature of Patient Date