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CONSENT AND AUTHORIZATION TO RELEASE INFORMATION OR MEDICAL, PSYCHIATRIC, PSYCHOLOGICAL & SUBSTANCE ABUSE RECORDS

Authorization for: ☐ Release of Information ☐ Request for Information

Patient's Name: _____

Parent/Guardian's Name: _____

Patient's Date of Birth: _____ SS#: _____

I hereby give permission to _____
to release written or verbal information to _____
for the purpose of evalutation and treament planning.

I understand that I may revoke this consent to release information at any time; however, I also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitue a breach of my right to confidentiality. Unless I revoke this authorization prior to such, this authorization to release information shall expire on _____. At that time no express revocation shall be needed to terminate my consent I hereby release the facility from any liabilty which may arise as a result of the use of the information contained in the records released.

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

To receiving agency: The information contained in this form is in compliance with Florida Statutes, Section 394.459 (9), and Federal Law, Title 42, CFR Chapter II, Part II.

Prohibition of Redisclosure: This information has been disclosed to you from records whose confidentiality is protected. Any further redisclosure is strictly prohibited unless the patient provides specific written consent for the subsequent disclosure of this information.