Center for Family Services

Authorization for Release of Protected Health Information

I, _____, hereby authorize the mutual release and disclosure
(Name of client, parent or guardian)
of information between the service providers identified below for the indicated purposes.

_____

_____
(Complete Name/title/agency/address/telephone)

Re: CLIENT NAME: _____

DATE OF BIRTH: ____/____/_____ SOCIAL SECURITY NUMBER: _____

SPECIFIC INFORMATION TO BE DISCLOSED:

____ Health History/Life History form
____ Bio Psycho Social Assessment
____ Diagnosis
____ Treatment/Action Plan
____ Chemical Use History & Assessment
____ Clinical Assessment
____ Other:_____

____ Treatment Summary
____ Summary of contacts
____ Treatment recommendations
____ Summary of progress
____ Termination Summary & Plan
____ Prognosis

PURPOSE & NEED FOR THE DISCLOSURE:

_____ Appropriateness for treatment
_____ Referral for service
_____ Coordination of treatment
_____ Further evaluation

____ Discharge planning
____ Reimbursement for service
____ Family involvement `
____ Other:_____

EAP DISCLOSURE:

____ Reason for referral
____ Confirmation of attendance
____ Other: _____

_____ Verification of progress
_____ Date of termination

I understand that I have the right to refuse this authorization and that the facility named above is released from all legal liability that may arise from the release of the information requested. I understand that any disclosure is bound by Title 42 of the Code of Federal Regulations (chemical abuse/addiction clients), and Florida Statutes 294.459 (9b) and/or 90.503 psychiatric/psychological information), and that re-disclosure of this information without my additional written authorization is prohibited. I understand the potential for information disclosed via this authorization to be potentially subject to re-disclosure by the recipient and no longer protected by the federal code. 45CFR164.508(c)(2)(iii) I also understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance upon it. This consent will automatically expire ninety (90) days after the date of this consent OR on the following earlier date, event or condition:
_____.

I certify that I have read the statement and information above and that I understand and agree to its content.

_____ _____
CLIENT SIGNATURE **GUARDIAN/PARENT SIGNATURE**

_____ _____
WITNESS SIGNATURE **RELATIONSHIP**

Date:_____ **Date:**_____