

Coastal Pinellas Behavioral Healthcare
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AUTHORIZATION TO RELEASE AND EXCHANGE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ Phone #: _____
(Please print)

I hereby authorize the below party to **communicate and exchange with [Insert Facility Name]** through disclosure and/or receipt of my confidential information.

Name of Person or Entity

Address

City

Phone # Fax #

Authorizes any past, present or future records to be disclosed unless otherwise specified.

Date range of records specified if applicable: _____

I acknowledge, and hereby consent to such that the released information may contain Substance Use Disorder and Psychiatric Information: _____ (Initial) Communicable disease including HIV/AIDS information. _____ (Initial)

Information that may be released:

- | | | |
|--|---|---|
| <input type="checkbox"/> Any and All Medical/Psychiatric Records | <input type="checkbox"/> Letter of Treatment | |
| <input type="checkbox"/> Any and All Substance Use D/O Records | <input type="checkbox"/> Biopsychosocial Evaluation | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Medication Record | <input type="checkbox"/> Physician's Psychiatric Evaluation | <input type="checkbox"/> Physician's Progress Notes |
| <input type="checkbox"/> History and Physical Exam Report | <input type="checkbox"/> Lab Results | <input type="checkbox"/> Nursing Notes |
| <input type="checkbox"/> Discharge Plan/Continuing Care Plan | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Clinical Progress Notes |
| <input type="checkbox"/> Other (specify): _____ | | |

PURPOSE FOR WHICH INFORMATION IS TO BE USED:

- | | | |
|--|-----------------------------------|--|
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> School | <input type="checkbox"/> Disability benefits |
| <input type="checkbox"/> Legal | <input type="checkbox"/> Personal | <input type="checkbox"/> Employment conditions |
| <input type="checkbox"/> Other (Must be specific): _____ | | |

Information may be disclosed by the following methods: US mail, verbal, faxing, and encrypted email unless otherwise specified.

Other Specified Method: _____

AUTHORIZATION:

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Revocation must be in writing. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure. Refer to the Notice for Privacy Practices regarding authorized disclosures. A legible copy of the Authorization or my signature thereon may be used with the same effectiveness as an original.

OTHER CONDITIONS:

This information has been disclosed to you from records whose confidentiality may be protected by Federal Law:

"I understand that my records are protected under Federal and State regulations governing the confidentiality and privacy of medical records and protected alcohol and drug abuse health information under 42 C.F.R Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R., Parts 160 and 164 and cannot be disclosed without my written authorization unless otherwise provided or by the regulations. I understand that I have a right to request a copy of this form. I understand that I might be denied services if I refuse to consent to a disclosure for treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to disclosure for other purposes. I also hereby release Coastal Pinellas Behavioral Healthcare from liability which may arise as a result of information disclosed under an authorization, if such information is disclosed is later used to my detriment".

This Authorization expires **1 year** from the date of signature unless otherwise specified: _____

Signature of Patient Date Signature of Parent/Guardian, if applicable Date

Witness, if applicable Date

Revocation: I hereby revoke the above authorization: Signature _____ Date _____