

RELEASE OF INFORMATION

Patient Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____

I authorize Compassionate Behavioral Health Care to release / obtain information from:

Name: _____

Relationship: _____

Phone: _____

Information to be released (Check all that apply):

Evaluation ☐ Test Results ☐ Progress Notes ☐ Medications ☐ Other _____

This authorization will expire in one year from the date I sign or unless I request an earlier expiration in writing.

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further redisclosure is strictly prohibited unless the person provides specific written consent for the subsequent disclosure of such information. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public records law. See s. 394.4615(1), Florida Statutes.

I understand that this form may be used to release information related to mental health treatment, including assessments and laboratory reports. Any release of information must be in compliance with the federal HIPAA law and state laws governing such releases. Any facility or private mental health practitioner who acts in good faith in releasing information pursuant to s. 394.4615 or other Florida statute is not subject to civil liability.

SIGNATURE

Patient's Signature: _____ Date:

Authorized Representative's Signature: _____ Date:

Representative's Name (printed): _____