Central Florida
BEHAVIORAL HOSPITAL
A Place for Help and Hope

Authorization to Release or Obtain Confidential Information

PATIENT NAME: _____ DATE OF BIRTH: _____

DATE OF ADMISSION: _____ SOCIAL SECURITY#: _____

I hereby authorize **Central Florida Behavioral Hospital** 6601 Central Florida Parkway, Orlando, FL 32821, Phone: 407-370-0111, Fax: 407-264-7740 to ☐ **RELEASE** and/or ☐ **OBTAIN** information by mail, courier or facsimile (fax) transmittal to/from:

PERSON OR ORGANIZATION:_____

ADDRESS:_____

CITY:_____ STATE: _____ ZIP: _____

PHONE: _____ FAX:_____

The following information is to be disclosed:

☐ **Transition Record**
- Part 1: Psych DC Final Note & Diagnosis
- Part 2: Aftercare / Discharge Plan
- Part 3: Discharge Medication Summary
- Part 4: Crisis Safety Plan
- Part 5: Advanced Directives

☐ Psychiatric Evaluation

☐ Demographic/Face Sheet
☐ Discharge Summary
☐ History & Physical Exam
☐ Intake Assessment
☐ Lab Tests / X-rays
  ☐ HIV Test Results
  ☐ STD Test Results

☐ Letter to verify Dates of Treatment
☐ Medication Administration Record (MAR)
☐ Medication Reconciliation Form
☐ Nutritional Assessment
☐ Psychiatric Evaluation
☐ Psychosocial Assessment
☐ Treatment Plan
☐ Other: _____

For the purpose of: ☐ **CONTINUING CARE** ☐ PERSONAL ☐ OTHER _____

Delivery Method: ____Mail(Paper) ____Mail CD/DVD (Digital) ___Pick-up(Paper) ___Fax

NOTICE TO PATIENT AND RECIPIENT OF RECORDS

I understand that this form may be used to release information related to mental health treatment. I further understand that the information disclosed may include psychiatric, drug/alcohol abuse and/or HIV data.

I understand that I have the right to refuse to sign this Authorization or to rescind my consent at any time prior to the release of the information. If I do not revoke this authorization it will **automatically expire 60 days from the date of signature unless otherwise noted** below. The consent is effective beginning on _____, and expires on _____, if not earlier revoked.

PATIENT'S SIGNATURE *(Under 18, must also sign by Florida Statutes)*	PRINTED PATIENT'S NAME *(Under 18, must also sign by Florida Statutes)*	DATE / TIME
When applicable, Signature of: ☐Parent ☐Guardian ☐ Guardian Advocate ☐ HealthCare Surrogate/Proxy ☐Personal Representative/Equivalent (if deceased) ☐ Power of Attorney	When applicable, Printed Name of: ☐Parent ☐Guardian ☐ Guardian Advocate ☐ HealthCare Surrogate/Proxy ☐Personal Representative/Equivalent (if deceased) ☐ Power of Attorney	DATE / TIME
Signature of Witness	Printed Name of Witness	DATE / TIME

This information has been disclosed to you from records protected by Federal confidentiality rules Florida Statutes 394-459, 397.501, and /or 90.503 and 42 Code of Federal Regulations (42 CFR). This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards) 45 CFR, 160 & 164, and all federal regulations and interpretative guidelines promulgated there under. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and Florida Statutes 394-459, 397.501, and /or 90.503. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I have been informed and understand that this authorization is subject to revocation by me at any time except to the extent that Central Florida Behavioral Hospital has already taken action in reliance on it. Once the requested protected health information is disclosed, the Privacy Regulation may no longer protect it if the PHI's recipient re-discloses it. Further, I understand that despite all care taken, information is occasionally received by a party not intended to be the recipient. I hereby release Central Florida Behavioral Hospital from all liability should this information be received by someone other than the above-intended recipient.