

Example Only



Authorization to Obtain / Release of Information

Fill in name

Fill in Date of Birth

Client Name: John Hancock

Client DOB: 01/01/01

By signing this authorization I hereby give permission to Families First of Florida to Release and or Request
___ written ___ verbal Information

Choose one or both

___ Release /Provide information to the agency or person listed below.

Choose one or both

___ Receive/Request information from the agency or person listed below.

***** Please note: Only one agency or person per release*****

___ Department of Children & Families ___ School Board: _____ County

___ Guardian ad Litem: _____

___ Dependency Case Management Agency: _____

___ Dependency Attorney: _____

Agency or Person: _____

Address: _____

Phone #: _____ Fax #: _____

Fill in info on who records will be released to or requested from.

Only one Agency or Person per form.

Choose what is to be released/requested

Please specify information to be released/ requested.

___ Psychiatric Evaluation ___ Treatment Plan ___ Psychiatric Progress Notes ___ Monthly Reports
___ Education Records ___ Bio-Psychosocial ___ Therapeutic Progress Notes ___ Med Management Notes
___ TCM Notes ___ TCM Service Plan ___ TCM Assessment Other (must specify) **Must be specific**

This information will be used for the purpose of coordinating my care, providing services to me and/or evaluating my needs. I understand that I have the right to refuse to sign this authorization and that my refusal to sign will not impact my right to treatment. I understand that any disclosure is bound by Title 42 of the Code of Federal Regulations, Part 2, and by Chapter 294.450, Florida Statutes.

By signing this authorization, I am agree to request records containing mental health, substance abuse and HIV information. Although the recipient of this information is authorized to release the information without additional written consent Families First of Florida cannot be held responsible for any further use or re-disclosure by the recipient.

Pick one or the other

This authorization is for a single use ___ or continuing use ___ and is valid for (1) year after the date of my signature or will expire on this date ___/___/_____. This authorization can be revoked at anytime upon written notice, revocation does not affect release/request prior to the notice.

Fill in date if other than 1 year

Signature of Client _____ Date _____

Sign and date

Signature of Legal Guardian _____ Date _____

Date

Printed name of Legal Guardian _____ Relationship to Client _____

Print name

Fill in Relationship to client

For use by Families First of Florida only

Abstract ___ Complete Medical ___ Complete Clinical ___ PE ___ TX Plan ___ Psychiatric Progress Notes ___
Therapeutic Progress Notes ___ Meds ___ Other _____ Date ___/___/____ Pg Count ___

Leave blank

Telephone Number (813) 290-8560 (Choose Your Service Center Accordingly)
Fax Numbers • Lakeland (863) 583-0392 • Marianna (850) 290-7442
• Ocala (352)354-9166 • Orlando (407) 386-7429 • Tampa (813) 354-2416