Authorization to Obtain / Release of Information

Client Name: _____ Client DOB: _____

By signing this authorization, I hereby give permission to Families First of Florida to Release and or Request
____written ____ verbal Information.

____Release /Provide information to the agency or person listed below.

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

<u>**** Please note: Only one agency or person per release******</u>**

____ Department of Children & Families ____ School Board: _____County

____ Guardian ad Litem: _____

____ Dependency Case Management Agency: _____

____Dependency Attorney: _____

Agency or Person: _____
Address: _____
Phone #: _____ Fax #: _____

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) _____

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 agreeing to release/request records containing mental health, substance abuse and HIV information. Although the recipient is not permitted to release the information without additional written consent Families First of Florida cannot be held responsible for further use or re-disclosure by the recipient.

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.

Signature of Client_____ Date _____

Signature of Legal Guardian_____ Date _____

Printed name of Legal Guardian _____ 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___

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 ● Pinellas Park (727) 683-9849 ● Tampa (813) 354-2416 ● Tallahassee (850) 290-7442
www.familiesfirstfl.com