Example Only

Families First OF FLORIDA

Fill in name

Authorization to Obtain / Release of Information

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.

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

Choose one or both

******** 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 agr quest records containing mental health, substance abuse and HIV information. Although the recipien to release the information without additional written consent Families First of Florida cannot be he 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/re est prior to the notice.

Fill in date if other than 1 year

Signature of Client_____ Date _____

Sign and date

Signature of Legal Guardian_____ Date _____

For minors guardian must sign

Date

Printed name of Legal Guardian _____ Relationship to Client _____

Fill in Relationship to client

Print name

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

Form 601 rev. 11/8/2017

Telephone Number (813) 290-8560 (Choose Your Service Center Accordingly)
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●Ocala (352)354-9166 ● Orlando (407) 386-7429 ● Tampa (813) 354-2416
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