** Authorization to Obtain / Release of Information**

**Fill in the Client’s Date of Birth**

**Fill in the Client’s Name**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this authorization, I hereby give permission to Families First of Florida to Release and or Request

**Must choose one or both**

\_\_\_\_written \_\_\_\_ verbal Information.

\_\_\_\_Release/Provide information to the agency or person listed below.

**Must 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Fill in info on who records will be released to or requested from.****Only one Agency or Person per form.** |
| \_\_\_\_Dependency Attorney: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Agency or Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |

**Please specify information to be released/requested.**

**Choose what is to be released/requested**

\_\_\_Psychiatric Evaluation \_\_\_ Treatment Plan \_\_\_ Psychiatric Progress Notes \_\_\_ Monthly Reports (Progress Summary)

\_\_\_ Education Records \_\_\_ Mental Health Assessment \_\_\_ Discharge Summary \_\_\_ Primary Care Records

\_\_\_TCM Notes \_\_\_ TCM Service Plan \_\_\_ TCM Assessment \_\_\_\_\_\_\_**Must be specific**\_\_\_\_\_\_\_\_ 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.

**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.

**For minors not receiving substance abuse treatment guardian must** **sign**

**Sign and date**

**Fill in date if other than 1 year**

Signature of Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**

Signature of Legal Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fill in relationship to client**

**Print name**

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\_\_\_*

**Leave blank**

Form 601 rev. 3/7/2019

***Telephone Number*** *(813) 290-8560* ***Choose*** *Records (Option 5)*

***Fax Number****813-354-2416*  ***Email Address*** *records@familiesfirstfl.com*

[*www.familiesfirstfl.com*](http://www.familiesfirstoffloridainc.com)