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**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.

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| **\*\*\*\*\*\* 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 #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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**Please specify information 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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\_\_\_*

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*](mailto:records@familiesfirstfl.com)

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