Families First OF FLORIDA

Authorization to Obtain / Release of Information

Fill in the Client's Name

Client Name: _____

Fill in the Client's Date of Birth

Client DOB: _____

By signing this authorization, I hereby give permission to Families First of Florida to Release and/or Request written and/or verbal protected health Information.

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

Agency or Person: _____

Address: _____

Phone #: _____

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

Only one Agency or Person per form.

Check what is to be released/requested

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)

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 agreeing to allow FFF 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 valid from one year from the date of my signature **or** will expire on __/__/____.

Fill in expiration date if other than 1 year

This authorization can be revoked at any time upon written notice, r notice.

Sign and Date

Signature of Client_____ Date _____

Signature of Legal Guardian_____ Date _____

For minors not receiving substance abuse treatment guardian must sign

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*** *Records (Option 5)*
Fax Number *813-354-2416* ***Email Address*** *records@familiesfirstfl.com*
www.familiesfirstfl.com