Directions for Living
LIFE GETS BETTER HERE.

Authorization to Release/Obtain Information

Phone: 727-524-4464 / Fax: 727-507-4856

Client Name: _____ DOB: _____

SSN: _____ Phone Number: _____

I hereby give permission to Directions for Living to:
Release/Provide Information to agency/person below: ☐ Yes ☐ No
Receive/Request Information from agency/person below: ☐ Yes ☐ No

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

The Specific Information to be disclosed is: INITIAL each item - either written (W) or verbal (V) or both

___W	___V	Psychiatric Evaluation	___W	___V	Bio-psychosocial Evaluation
___W	___V	Psychiatric Follow Up Notes	___W	___V	Clinical Progress Notes
___W	___V	Lab, X-Ray, EKG, EGG, CT Scan	___W	___V	Treatment Plan(s)
___W	___V	Medication List	___W	___V	Psychological Testing
___W	___V	Drug/ Alcohol Treatment	___W	___V	Treatment Summary
___W	___V	Appt. Scheduling/Re-Scheduling/ Confirmation	___W	___V	Discharge Summary
___W	___V	Other (must specify): _____			

Date Range of Records to be Released ☐ All **OR** FROM (month/year): _____ TO (month/year): _____
Please make a selection: ☐ Release Records Now **OR** ☐ File until a Request for Records is Made

Purpose of Release: This information is being released, received, and used for the purposes of coordinating my care, evaluating my needs, and/or providing services to me. If other, please explain: _____
I understand that I have the right to refuse to sign this authorization and that my treatment is not contingent upon whether or not I sign this authorization. I further understand that I am agreeing to share confidential information that is protected by state and federal laws governing confidentiality of alcohol, drug abuse, mental health, and HIV patient records (42 CFR Part2; FS 394; FS 381). Although anyone who receives my records from this Organization is not permitted to release them to anyone else without additional written consent I understand that Directions cannot guarantee that subsequent re-disclosure will not happen. I hereby release the issuing Organization/person from any liability, which may arise as a result of the use of the information contained in the copies of records released, as a result of this authorization, if such information is later used to my detriment. **I understand that there may be fees incurred to cover copy services.** I also understand I have the right to inspect or copy the health information disclosed.
Duration of Authorization: This authorization is **valid for two (2) years** after the date of my signature as it appears below **OR valid from** _____ to _____. This authorization may be revoked at any time upon written notification by the signatory or client, but revocation has no effect on previously taken action.
I have been offered a copy of this authorization.

Signature of Client: _____ Date: _____

Signature of Legally Empowered Representative: _____ Date: _____

Relationship to Client: _____

Witness: (MUST be witnessed to be valid) _____ Date: _____

Employee ID: _____
Client ID: _____