



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

Initial each one that applies:

- Safe Harbor: 14840 49th St. N., Clearwater, FL 33762 / P: (727) 464-8058 / F: (727) 453-7778
Public Defender's Office: 14250 49th St. N., Clearwater, FL 33762 / P: (727) 464-6516 / F: (727) 464-6119
Operation PAR: 6655 66th St. N., Pinellas Park, FL 33781 / P: (727) 545-7564 / F: (727) 545-7584
ACTS: 3575 Old Keystone Rd., Tarpon Springs, FL 34688 / P: (727) 935-0295 / F: (727) 937-3659
Boley Centers: 445 31st N., St. Petersburg FL, 33713 Phone / P: (727) 821-4819 / F: (727) 490-0538
Morton Plant Hospital: 300 Pinellas St., Clearwater, FL 33756 / P: (727) 461-8601 / F: (727) 461-8849
PEMHS: 11254 58th St. N., Pinellas Park, FL 33782 / P: (727) 545-6477 / F: (727) 549-6074
Suncoast Center: 4024 Central Ave., St. Petersburg, FL 33711 / P: (727) 327-7656 / F: (727) 322-2109
Bay Pines VA: 10,000 Bay Pines Blvd., Bay Pines, FL 33744 / P: (727) 398-6661 / F: (727) 398-9543
Windmoor: 11300 U.S. 19 N., Clearwater, FL 33764 / P: (727) 541-2646 / F: (727) 322-7205
Westcare: 2525 1st Ave. S., St. Petersburg, FL 33712 / P: (727) 490-6768 / F: (727) 541-3993
St. Anthony's Hospital: 1200 7th Ave. N., St. Petersburg, FL 33705 / P: (727) 825-1100 / F: (727) 825-1344
Largo Medical Center: 201 14th St. S.W., Largo, FL 33770 / P: (727) 588-5200 / F: (855) 446-6008
Pinellas County Health and Human Services: 647 1st Ave. N., St. Petersburg, FL 33701 / P: (727) 464-4200 / F: (727) 464-8591
Community Health Centers of Pinellas: 1344 22nd St. S., St. Petersburg, FL 33712 / P: (727) 824-8181 / F: (727) 824-8150
Pinellas County Health Departments: 205 Dr. Martin Luther King Jr. St. N. Suite 2-173, St. Petersburg FL, 33701 / P: (727) 824-6900 / F: (727) 820-4163

Other 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 for Living 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 are 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 one (1) year** after the date of my signature as it appears below **OR valid from** _____ to _____. This authorization will become invalid upon my discharge from the agency. 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. During a State of Emergency, or when meeting face to face poses a significant threat to the health and safety of the client or employee, the use of verbal consent will be allowed with the witness of two DFL employees.

Signature of Client: _____ Date: _____

Signature of Legally Empowered Representative: _____ Date: _____

Relationship to Client: _____

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