Directions for Living
LIFE GETS BETTER HERE.

Authorization to Release/Obtain Information

Phone: 727-524-4464 / Fax: 727-507-4856/ HIM@directionsforliving.org

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

Only initial agencies you've attended. If none apply, complete the blank Other Agency or Person section.

_____**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

_____**Eleos:** 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)322-2157

_____**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) 582-7912 / F: (727) 582-7589

_____**Bayside Clinic/Mobile Medical Unit:** 14808 49th St. N, Clearwater FL 33762/ P: (727)453-7866/ F: (727)582-7912

_____**Evara Health:** 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) 373-5959

___**Guardian ad Litem Office:** 14250 49th St N #4000, Clearwater, FL 33762 / P: (727) 464-6528 / F: (727) 464-7674/ email: Pinellasc6.caserecords@gal.fl.gov

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 Psychiatric Follow Up Notes
_____W_____V Lab, X-Ray, EKG, EGG, CT Scan
_____W_____V Medication List
_____W_____V Drug/ Alcohol Treatment/Test Results
_____W_____V Appointment Information
_____W_____V Billing Information
_____W_____V Other (must specify):_____

_____W_____V Bio-psychosocial Evaluation
_____W_____V Clinical Progress Notes
_____W_____V Treatment Plan(s)
_____W_____V Psychological Evaluation
_____W_____V Treatment Summary
_____W_____V Discharge Summary

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 I am approving to share all records that I have granted permission to disclose above including 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). **If I, the client, only allow the release of a certain date range of medical records held by Directions for Living, please specify: (month/date)** _____ to **(month/date)**_____. 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** It is my wish that this release **expire prior to 1 year on (month/date)**_____. This authorization will become invalid upon my discharge from the agency, or, for children below the age of 18, and non-emancipated, on my 18th birthday if signed by a parent/legal guardian without supporting legal documentation to prove rights to the medical record. 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.

Printed Name of Client: _____

Signature of Client:_____ Date: _____

Printed Name of Legally Empowered Representative: _____

Signature of Legally Empowered Representative:_____ Date: _____

Relationship to Client:_____

Printed Name of Witness: (MUST be witnessed to be valid)_____

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

Please make a selection:

☐ Release Records Now, if multiple agencies were selected above, please specify agency to release: _____

☐ Request Records Now, if multiple agencies were selected above, please specify agency to request: _____

OR

☐ This release is only to be held on file for future/continued use.