



Authorization to Release/Obtain Information

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

Client Name: _____ DOB: _____

SSN: _____ Phone Number: _____

2

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

3

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) 934-0123
- ___ **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) 462-7500 / F: (727) 462-7654
- ___ **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 #: _____

4

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

7

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.

8

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.

I have been offered a copy of this authorization.

9

Signature of Client: _____ Date: _____

Signature of Legally Empowered Representative: _____ Date: _____

Relationship to Client: _____

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

Authorization to Release/Obtain Information Instructions

The following steps **must** be taken for this form to be considered a **valid** authorization of information exchange.

1. The name and date of birth for the client giving this authorization must be included.
2. The client must make a selection as to whether they want information released "to" and/or "from" the agency listed below. Selecting "to" allows Directions for Living to release information to the agency of the client's choosing. Selecting "from" allows Directions for Living to obtain information from the agency of the client's choosing.
3. The client must select the agencies for whom they are making this authorization by initializing next to each item. If the client wants to add an additional agency, they must write the name of the agency or person for whom they are making this authorization. They must include at least one of the following modes of communication to assure information is being communicated to or from the correct party: address, phone number, or fax number.
4. The client must select at least one specific piece of information to disclose by initialing next to each item. This includes selecting the mode of communication as being either verbal or written for each piece of information selected. It is important to note that the client should only select the specific information they want released, rather than initialing on every line.
5. The client must specify whether they want all of their records released or they want their records released for a certain period of time, which they will need to fill in.
6. The client must specify whether they want the authorization to be acted upon now or if they want it to be filed in case information needs to be communicated at a later date.
7. If the client is making this authorization for reasons other than those listed on the form, the client must fill in the reason.
8. The client can restrict for how long the authorization is valid. If they elect not to do so, the authorization is assumed to be valid for one year from the date it was signed.
9. The client, their legally empowered representative (parent, guardian, etc.), and a witness (team member completing the form with the client) must sign and date this form.
10. In the bottom right hand corner of both pages, the client ID and team member's employee number must be included.

If you have further questions regarding how to complete this authorization, please contact HIM at 727-524-4464 x1208.