AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

P.O. Box 10970|St. Petersburg FL 33733

Phone: (727) 327-7656 ext. 4055 Fax: (727) 322-2157

Client Name (Please Print): _____ Alias: _____

Date of Birth: _____ Client SSN (Last 4 digits): _____ Phone(s): _____

I hereby freely authorize Suncoast Center, Inc. to:

_____ (client initials) Release/Disclose my protected health information to:

_____ (client initials) Obtain my protected health information from:

_____

Name of Person/Entity **Phone** **Fax**

_____

Address

_____

City **State** **Zip**

I _____ (client initials) understand that my records are protected under the federal and state regulations governing the confidentiality and privacy of medical records and protected alcohol and drug abuse health information under 42 CFR, Part 2 and the Health insurance portability and Accountability Act of 1996 (HIPAA) 45 CFR Parts 160 and 164 and cannot be disclosed without my written authorization unless otherwise provided for by the regulations.

I_____ (client initials) hereby authorize any of the parties designated above to communicate with one another through disclosure, receipt and use of my confidential information for purposes of evaluating my need, coordinating and/or providing me services.

The nature and amount of information that may be disclosed, received and /or used by the parties pursuant to this authorization is as follows:

Initial each requested. A check mark will not authorize release.

Dates of Service: _____

_____ Attendance and Compliance Records
_____ Lab Results
_____ Psychiatric Diagnosis Notes
_____ Psychiatric Medication Management Notes
_____ Psychotherapy Progress Notes
____ Date and Status of Discharge
____ My Identity as an Applicant for Services
____ Psychiatric Evaluation Notes
____ Psychosocial Assessment
____ Treatment Plans
Other (Must Specify): _____

I understand that the information in my health record may include information related to sexually transmitted diseases, acquired or mental health services and treatment of alcohol or drug abuse.

State and Federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained.

Initial each requested. A check mark will not authorize release.

_____ Alcohol, Drug or Substance Abuse Records
_____ HIV Testing Results
_____ Genetic Records

PURPOSE FOR REQUESTING INFORMATION:

_____ Continuation of Care _____ Personal _____Insurance
_____ Legal (Must Specify): _____
_____ Other (Must Specify): _____

DISCLOSURE FORMAT:

_____ Paper Copy ____US Mail ____ Fax Number_____
_____ Secure Electronic Exchange _____Secure Email (Please Print) _____

By signing this authorization form, I understand that:

- My records are in privileged and confidential status, I am waiving that status for the purpose contained within this authorization.
- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: 4024 Central Avenue, St Petersburg, FL 33711. Revocation will not apply to any information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/ condition: If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.

- I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment or health care operations if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.
- This information will be disclosed from records whose confidentiality and privileged status are protected by the Florida Statute 394.4615 and Federal law 42 CFR, Part 2. These regulations prohibit making any further disclosure of this information except to the intended recipients; however, any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.

This authorization is for _____(client initials) **single** or _____(client initials) **continuing disclosure** valid until _____(not valid for more than 365 days).

By my signature below, I acknowledge that I have given my consent as indicated above freely, voluntarily and without coercion, signed by me on the date shown below.

_____

Signature of Client/Client's Representative (Legal papers must accompany release) **Date**

_____

Print Name of Client's Representative **Relationship to Client**

_____

Witnessed by

State of _____

County of_____

I, an officer authorized to take acknowledgments in the State and County aforesaid, do hereby certify that on this date _____ _____ did personally appear before me, and known to me to be the person described in the foregoing instrument, did execute said instrument freely and voluntarily, and for the purposes contained therein.

WITNESS my hand and seal this _____ day of _ A.D. 20_____

_____ _____

Notary Public **My commission expires**

Revocation: I hereby revoke the above authorization: _____

Signature **Date**

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Directions for Completing the Authorization for Release of Protected Health Information (PHI)

1. Provide the client's name, Alias (if applicable), date of birth, SSN (last 4 digits) and phone number.
2. Under "***I hereby freely authorize Suncoast Center, Inc. to:"*** choose and enter the client initials next to ***Release/disclose my protected health information*** or ***Obtain my protected health information***.
3. Provide the name, phone number, fax and address of the person or entity that is to release or obtain the PHI.
4. Enter the client initials to acknowledge understanding that records requested are protected under Federal and State regulations governing the confidentiality and privacy of medical records and protected alcohol and drug abuse health information under 42 CFR, Part 2 and the Health insurance portability and Accountability Act of 1996 (HIPAA) 45 CFR Parts 160 and 164 and cannot be disclosed without my written authorization unless otherwise provided for by the regulations.
5. Enter the client initials to authorize any of the parties designated above to communicate with one another through disclosure, receipt and use of my confidential information for purposes of evaluating my need, coordinating and/or providing me services.
6. Provide the Dates of Service for the PHI requested to be disclosed.
7. Enter the client initials next to the PHI that is to be disclosed. A check mark will ***not*** authorize release. If "Other" is initialed, specify what PHI is being requested.
8. Enter client initials next to Alcohol, Drug or Substance abuse Records, HIV Testing Results or Genetic Records if you would like this information released/obtained
9. Under ***"Purpose for requesting Information"*** check the purpose: Continuation of Care, Personal, Insurance, Legal or Other. If "Legal or Other" is checked, specify what the purpose for disclosure is.
10. Under ***"Disclosure Format"*** check the format: Paper Copy, US Mail, Fax, Secure Electronic Exchange or Secure Email.
11. Enter the client initials to designate whether the authorization is to be used for single or continuing disclosure and document how long the authorization is valid (not valid for more than 365 days).
12. The client or the client's representative (i.e. guardian, legal power of attorney or healthcare surrogate) must sign, date, print name and relationship to client (when applicable).
13. Notarize document. (Notary Services are provided by most banks).

There may be a copy fee for the information requested. If you are required to pay a fee for copies or completing your request, there will be a charge of $1.00/page for the first 25 pages and $.25 for each additional page.

***Please send a copy of the client's ID or the legal paperwork along with this request to the address above.**