Authorization for Release/Exchange of Information

Patient Name: ______________________________________ Date of Birth: _________________________

I voluntarily authorize the following named organization:

Gulfcoast Behavioral Health	Telephone Number:	727-726-7442
1938 Soule Rd	Facsimile Number:	727-288-1111
Clearwater, FL 33759	Email Address:	INFO@GULFCOASTBH.COM

To release/discuss/obtain a copy of my Protected Health Information (PHI) to/from:

Name: ____ Phone #: _____________________________

Address: ____ Fax #: _______________________________

City: _________________ State: ______ Zip: _______ Email: ____________________________________

For the purpose of: [ ] Personal [ ] Treatment (continued care) [ ] Other: _________________________

Form of Disclosure: [ ] Written [ ] Verbal [ ] Fax [ ] Email

Check all appropriate boxes below.

[ ] Office Notes [ ] Laboratory/Diagnostic Results [ ] Admission/Discharge Summary

[ ] Complete Record [ ] Forms/Letter [ ] Other (please describe): _____________________

EFFECTIVE TIME PERIOD: This authorization is valid for two (2) years after the date of my signature as it appears below; or the following specific date (optional): ______________________.

I understand that I am agreeing to share confidential information that is protected by state and federal laws governing confidentiality of alcohol and drug abuse, mental health, and HIV/AIDS client records (42 CFR Part2; FS 394; FS 381).

Anyone who receives my records from this organization is not permitted to release them to anyone else without additional written consent. I understand that Gulfcoast Behavioral Health cannot guarantee that subsequent re-disclosure will not occur. I hereby release Gulfcoast Behavioral Health from any liability which may arise because of the use of the information contained in copies of records released, because of this authorization, if such information is later used to my detriment. I understand that I need not sign this authorization to ensure treatment.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the office. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

By signing, I hereby acknowledge that I have read, understand, and acknowledge all the above. I agree that a copy and/or electronic signature below may substitute as the original and is the legal equivalent of my manual/handwritten/original signature.

____ ____________________________

Patient or Legal Guardian Signature Date