Authorization to Obtain / Release of Information

Client Name: _____ Client DOB: _____

By signing this authorization, I hereby give permission to Families Connect Inc. (FCI) to Release and/or Request written and/or verbal protected health Information.

******** Please note: Only one agency or person per release********

Agency or Person: _____

Address: _____

Phone #: _____ Fax #: _____

MUST specify information to be released/requested.

___ Treatment Plan ___ Monthly Reports (Progress Summary) __ Mental Health Assessment ___ Discharge Summary

This information will be used for the purpose of coordinating my care, providing services to me, and/or evaluating my needs. I understand that I have the right to refuse to sign this authorization and that my refusal to sign will not impact my right to treatment. I understand that any disclosure is bound by Title 42 of the Code of Federal Regulations, Part 2, and by Chapter 294.450, Florida Statutes.

By signing this authorization, I agree to allow FCI to release/request records containing mental health, substance abuse, HIV and gender affirming information. Although the recipient is not permitted to release the information without additional written consent Families Connect Inc. cannot be held responsible for further use or re-disclosure by the recipient. FCI will send/provide Electronic Health Information (EHI) in a secure manner, however if the client or the client's personal representative who has been granted the authority to make healthcare decisions asks FCI to send EHI to an unsecure destination/device then FCI cannot be held liable for third party release or redisclosure.

This authorization is valid from one year from the date of my signature.

This authorization can be revoked at any time upon written notice, revocation does not affect release/request prior to the notice.

Signature of Client_____ Signature Date _____

Signature of Legal Guardian_____ Signature Date _____

Printed name of Legal Guardian _____ Relationship to Client _____

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