

# Coastal Mental Health Center, Inc.

**Jacksonville**  
8382 Baymeadows Road  
Suite 7  
Jacksonville, FL 32256

**Leesburg**  
8136 Centralia CT  
Suite 101  
Leesburg, FL 34788

**Orange City**  
300 Treemont Drive  
Orange City, FL 32763

**Sanford**  
101 Bellagio Circle  
Sanford, FL 32771

**Orlando**  
1320 N. Semoran Blvd  
Suite 107  
Orlando, FL 32807

**Daytona**  
801 Beville Rd  
Suite 202A  
South Daytona, FL 32119

**Saint Cloud**  
2900 17th Street  
Suite 3  
Saint Cloud, FL 34769

**Palm Bay**  
5200 Babcock Street NE  
Suite 105  
Palm Bay, FL 32905

**Rockledge**  
1282 Rockledge Blvd  
Suite 2  
Rockledge, FL 32955

## AUTHORIZATION TO RELEASE OR OBTAIN CONFIDENTIAL INFORMATION

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

DATE OF ADMISSION: \_\_\_\_\_ SOCIAL SECURITY: \_\_\_\_\_

I hereby authorize Coastal Mental Health Center to RELEASE or OBTAIN information by mail, courier or facsimile (fax) transmittal to/from:  
PERSON OR ORGANIZATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

The following information is to be disclosed:

- Entire Medical Records  Lab Tests / X-rays  History & Physical Examination  
 IEP / School Records  Other: (specify) \_\_\_\_\_

(Psychotherapy notes are excluded)

For the purpose of:  CONTINUING CARE  PERSONAL  OTHER \_\_\_\_\_

(Psychotherapy notes are excluded)

### NOTICE TO PATIENT AND RECIPIENT OF RECORDS

I understand that this form may be used to release information related to mental health treatment. I further understand that the information disclosed may include psychiatric, drug/alcohol abuse and/or HIV data.

I understand that I have the right to refuse to sign this Authorization or to rescind my consent at any time prior to the release of the information. If I do not revoke this authorization it will automatically expire 60 days from the date of signature unless otherwise noted below. The consent is effective beginning on \_\_\_\_\_, and expires on \_\_\_\_\_, if not earlier revoked.

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
PRINTED PATIENT'S NAME

\_\_\_\_\_  
DATE / TIME

When applicable, Signature of:  Parent

- Guardian  Guardian Advocate  
 HealthCare Surrogate/Proxy  
 Personal Representative/Equivalent (if deceased)  
 Power of Attorney

When applicable, Printed Name of:  Parent

- Guardian  Guardian Advocate  
 HealthCare Surrogate/Proxy  
 Personal Representative/Equivalent (if deceased)  
 Power of Attorney

\_\_\_\_\_  
DATE / TIME

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Printed Name of Witness

\_\_\_\_\_  
DATE / TIME

[www.coastalmhc.com](http://www.coastalmhc.com) \* (P) 800-614-4124 \* (F) 888-217-4124

This information has been disclosed to you from records protected by Federal confidentiality rules Florida Statutes 394-459, 397.501, and / or 90.503 and 42 Code of Federal Regulations (42 CFR). This Release of Information demonstrates compliance with the Health Insurance Portability and accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards) 45 CFR, 160 & 164, and all federal regulations and interpretative guidelines promulgated there under. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and Florida Statutes 394-459, 397.501, and/or 90.503. a general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I have been informed and understand that this authorization is subject to revocation by me at any time except to the extent that Coastal Mental Health Center has already taken action in reliance on it. Once the requested protected health information is disclosed, the Privacy Regulation may no longer protect it if the PHI's recipient re-discloses it. Further, I understand that despite all care taken, information is occasionally received by a party not intended to be the recipient. I hereby release Coastal Mental Health Center from all liability should this information be received by someone other than the above-intended recipient.