COASTAL MENTAL HEALTH CENTER

☐ **Orange City**	☐ **Daytona**	☐ **Palm Coast**	☐ **Rockledge**	☐ **Leesburg**
300 Treemont Dr	1673 Mason Ave, Ste. 204	31 Lupi Crt, Ste. 210	571 Haverty Crt. Ste.Y	734 N. Third St. Ste 105
Orange City, FL 32763	Daytona Beach FL, 32117	Palm Coast, FL 32137	Rockledge, FL 32955	Leesburg, FL 34748
☐ **Palm Bay**	☐ **Orlando**	☐ **Clermont**	☐ **Kissimmee**	☐ **Sanford**
4620 Lipscombe NE, Ste. 3	931 S. Semoran Blvd., Unit 206	15701 Hwy 50, Suite 203	829 E. Oak St., Ste. C	540 W. Lake Mary Blvd.
Palm Bay, FL 32905	Winter Park, FL 32792	Clermont FL 34711	Kissimmee, FL 34744	Sanford, FL 32773

(Please send records to the program selected above)

Phone: 1-800-614-4124 Fax: 1-888-217-4124

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 (Under 18, must also sign by Florida Statutes)	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

This information has been disclosed to you from records protected by Federal confidentiality rules Florida Statues 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 (HIPPA), 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 Statues 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.