COASTAL MENTAL HEALTH CENTER

☐ **Orange City**
300 Treemont Dr
Orange City, FL 32763

☐ **Daytona**
801 Beville Rd, Ste. 202A
South Daytona Beach FL, 32117

☐ **Rockledge**
1260 Rockledge Blvd. Ste 202
Rockledge, FL 32955

☐ **Leesburg**
120 East North Blvd.
Leesburg, FL 34748

☐ **Palm Bay**
5200 Babcock St NE, Ste. 105
Palm Bay, FL 32905

☐ **Orlando**
1320 N. Semoran Blvd., Ste. 107
Orlando, FL 32807

☐ **Saint Cloud**
2900 17th Street, Ste. 3
St. Cloud, FL 34769

☐ **Sanford**
520 W. Lake Mary Blvd. Ste. 204
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 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.