SANTA ROSA COUNSELING CENTER
Therapy & Psychiatric Services

Authorization for Release of Confidential Information

INTRODUCTION

This document authorizes Santa Rosa Counseling Center LLC to release and obtain protected and confidential information including, but not limited to, medical, mental health, substance abuse treatment, legal, academic, and vocational records as specified below. The release of third-party information, including records received from other providers, is authorized unless otherwise specified or prohibited. Information may be released verbally, in copy form, or electronically to include fax and/or computer transmission. The records owner or custodian is authorized to act on behalf of a copy of this original form.

PATIENT INFORMATION

Last Name _____ First _____ MI _____ Date of Birth _____ SSN _____

Persons and Agencies to Obtain and/or Release Information *(may include multiple parties)*

- ☐ Health Insurance Provider
- ☐ Baptist Hospital
- ☐ Lakeview Center, Inc.
- ☐ Santa Rosa Medical Center
- ☐ HCA Florida West Hospital / The Pavilion
- ☐ Sacred Heart Hospital
- ☐ Department of Children and Families
- ☐ FamiliesFirst Network
- ☐ Guardian ad litem Program
- ☐ County and State Court / Probation _____
- ☐ Primary Care Provider _____
- ☐ Psychiatric Provider _____
- ☐ Attorney _____
- ☐ Other _____

The entirety of my record may be released/obtained. Otherwise, the following limitations of disclosure are as follows:

_____

I acknowledge that I am giving permission to disclose or obtain Protected Health Information. I understand that I may refuse to sign this authorization or that I may revoke this authorization in writing at any time except for that action which has already been taken to comply with it. I understand that treatment may not be conditioned on whether I sign this authorization, but that in certain limited circumstances I may be denied treatment if I refuse to sign this authorization. There is a potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPAA Privacy Rule. I understand that if I am a criminal justice system referral, this consent will remain in effect and cannot be revoked by me until there has been a formal termination of my probation, parole, conditional release, or other proceeding under which I was mandated into treatment.

This authorization is valid until termination of services unless specified: _____

Patient Name _____ Patient / Guardian Signature _____ Date _____

Witness Name _____ Witness Signature _____ Date _____

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). 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. 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.