BLUEWATER BEHAVIORAL HEALTH

4400 East Highway 20, Suite #313, Niceville, FL 32578* Phone (850) 797-2598 * Fax (850) 807-5127

AUTHORIZATION FOR RELEASE OF INFORMATION TO ANOTHER PERSON

Patient Name: _____ DOB: _____

Practice/Provider: Dr. Leigh Powers DNP, APRN, PMHNP/BC, Bluewater Behavioral Health, Inc.

Please list below the name(s) of family members or other individuals, if any, to whom he may release your personal medical/psychiatric information. If authorized, Bluewater Behavioral Health may release your information to any authorized person(s) in person or via telephone or email regarding your general condition and/or diagnoses (including treatment, payment, and health care operations).

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

NOTICE: This authorization is for full disclosure of pertinent mental health treatment records, including HIV test results, alcohol and drug therapy, and lab reports. If there is any information that you do not want disclosed to the named party, please indicate below what portions of the record you would like excluded.

Exclusions: _____

My signature below indicates that I hereby grant Bluewater Behavioral Health the approval to discuss my medical/psychiatric history as outlined above. Any exclusions have been noted. I understand that this authorization is voluntary and will remain in effect until I rescind myself in writing.

Patient Signature: _____ Date:_____

Witness Name: _____ Witness Signature: _____