Space Coast Psychiatry

Authorization to Release or Obtain Confidential Information

PATIENT NAME: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

I hereby authorize Space Coast Psychiatry located at 465 Minutemen Cswy, Suite 485, Cocoa Beach, FL 32931, Phone: 321-613-5595 & Fax: 321-613-4877 to ☐ **RELEASE and/or** ☐ **OBTAIN** (√ one or both) information by mail, courier or facsimile (fax) transmittal to/from:

PERSON OR ORGANIZATION: _____

ADDRESS: _____CITY: _____

STATE: _____ ZIP CODE: _____ EMAIL: _____

PHONE: _____ FAX: _____

The following information is to be disclosed:

☐ All Medical Records	☐ Consultations	☐ Clinical Summary
☐ All Mental Health Records	☐ Psychosocial Assessment	☐ Letter to State Dates of Treatment
☐ Psychiatric Evaluation	☐ Nutritional Assessment	☐ IEP/School Records
☐ History & Physical Exam	☐ Lab Tests/X-rays	☐ Physician Progress Notes
☐ Discharge Summary	☐ Baker Act Form	☐ Other
☐ Treatment Plan		

For the purpose of: ☐ CONTINUING CARE ☐ PERSONAL ☐ OTHER _____

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 12 months from the date of signature unless otherwise noted below.

_____	_____	_____
PATIENT'S SIGNATURE (Age 14 and older, must also sign)	PRINTED PATIENT'S NAME	DATE
_____	_____	_____
When applicable, Signature of: ☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other _____	Printed Name of: ☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other _____	DATE
_____	_____	_____
Signature of Witness	Printed Name of Witness	DATE

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 (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 Statutes 394-459, 397.501, and/or 90.503. A general authorization for the 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 Space Coast Psychiatry, Inc. 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 Space Coast Psychiatry, Inc. from all liability should this information be received by someone other than the above-intended recipient.