gulfcoast BEHAVIORAL HEALTH
1938 SOULE ROAD, CLEARWATER, FL 33759 Ph. (727) 726-7442 F. (727) 288-1111 www.gulfcoastbh.com

Authorization for Release/Exchange of Information

Patient Name: _____ Date of Birth: _____

To ensure effective communication and continuity for myself/my child, I authorize the sharing of relevant treatment information between:

Gulf Coast Behavioral Health	Phone Number:	(727) 726-7442
1938 Soule Rd	Fax Number:	(727) 288-1111
Clearwater, FL 33759	Email Address:	info@gulfcoastbh.com

and the Individual, Physician/Treatment Provider, Office, or Hospital identified below:

Name/Organization: _____ Phone Number: _____

Specific information to be disclosed:
Check all appropriate boxes below:

☐ Office Notes ☐ Laboratory/Diagnostic Results ☐ Admission/Discharge Summary

☐ Complete Record ☐ Forms/Letter ☐ Other (please describe): _____

I understand that information disclosed under this authorization will be protected in accordance with applicable local, state, and federal privacy laws, including HIPAA. This authorization may include the release of confidential information related to mental health, substance use treatment, and HIV/AIDS records as permitted by law, including 42 CFR Part 2 and F.S. §382.010.

I understand that information released under this authorization may not be re-disclosed without my additional written consent unless otherwise permitted by law. Gulf Coast Behavioral Health cannot guarantee against unauthorized re-disclosure by the recipient.

I release Gulf Coast Behavioral Health, its employees, agents, and representatives from liability for the good-faith disclosure of information authorized herein.

I understand that I may revoke this authorization at any time by submitting a written request. Any revocation will not apply to information that has already been disclosed in reliance on this authorization. For minor patients, this authorization will terminate when the patient reaches the age of majority, unless otherwise authorized by law, whichever comes first.

By signing below, I acknowledge that I have read and understand this authorization and voluntarily consent to the release and exchange of the information described herein for treatment, care coordination, and continuity of care. I understand that a photocopy, facsimile, scanned copy, or electronic signature shall be as valid as the original and have the same legal effect. If the patient is a minor, I certify that I am the parent or legal guardian and have the legal authority to authorize the release and exchange of the minor's protected health information as described in this authorization. By signing below, I consent to the disclosure of such information on the minor's behalf.

_____ _____
Patient/Legal Guardian Signature Date

_____
Relationship to Patient

Clear Form