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

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

Name: _____

DOB: _____ SS#: _____

Phone: _____ Client Acct #: _____

I hereby give permission to Gulfcoast Behavioral Health to:

Release Information to: Yes ☑ No ☐

Receive Information from: Yes ☑ No ☐

Agency or Person: _____

Address: _____ City: _____ St: _____ Zip: _____

Telephone: _____ Fax: _____ Email: _____

The specific information to be disclosed: Written ☐ Verbal ☐ or Electronic ☐

- ☐ Psychiatric Evaluation
- ☐ Medication Profile
- ☐ Treatment Plan
- ☐ Progress Notes
- ☐ Psychotherapy Notes
- ☐ Labs/Test Results
- ☐ Family History
- ☐ Treatment Summary
- ☐ Billing/Payments
- ☐ Appointments
- ☐ Other (Specify):_____

For the purpose: _____

I understand that I have the right to refuse to sign this authorization.

I further understand that I am agreeing to share confidential information that is protected by state and federal laws governing confidentiality of alcohol and drug abuse, mental health, and HIV client records (42 CFR Part2; FS 394; FS 381). Although anyone who receives my records from this organization is not permitted to release them to anyone else without additional written consent, I understand that Gulfcoast Behavioral Health cannot guarantee that subsequent re-disclosure will not occur. I hereby release Gulfcoast Behavioral Health from any liability which may arise as a result of the use of the information contained in copies of records released, as a result of this authorization, if such information is later used to my detriment.

This authorization is for a single ☐ or continuing ☑ disclosure, valid for two (2) years after the date of my signature as it appears below, or from _____, 20_____ to _____, 20_____.

This authorization may be revoked at any time upon written notification by the signatory or client, but revocation has no effect on action previously taken. I have been offered a copy of this authorization.

_____ _____
Client Signature **Date**

_____ _____
Legal Representative / Parent Signature **Date**

_____ _____
Office Staff Signature **Date**

Administrative Instructions

___ File Only
___ Send Records to Agency or Person
___ Request Records from Agency or Person
___ Send (form, letter, etc) Now
___ Other: _____