**AUTHORIZATION** **FOR** **RELEASE** **OF** **INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **Client Name:** |  | **FSFN Case ID:** |  |
| **DOB:** |  | **SSN:** |  |

Permission is hereby given to Communities Connected for Kids to () release and/or () request information including medical, psychiatric, psychological, drug, alcohol, HIV and AIDS contained in the medical records of the above‐referenced client.

Name of person, agency or organization to which information is to be () released and/or from whom information is to be () requested/obtained:

|  |  |  |
| --- | --- | --- |
|  |  |  |
| (*Name of person, agency or organization*) |  | (*Address, Phone/Fax*) |

The purpose of releasing this information is:

Specific information to be released is:

Specific dates of service for which information is requested:

This release shall be in compliance with federal regulations (42 CFR Part 2) and with all applicable state and local laws, rules and regulations. Provision of services is not dependent upon the client’s/representative’s decision regarding release of information. The client/representative has been given the opportunity to discuss the possible benefits and disadvantages of releasing the information. This authorization is freely and voluntarily given.

Any release of mental health and substance abuse information must be pursuant to F.S.A. §455.667, F.S.A §397.501(7), 42 U.S.C. §290dd‐2, 42 C.F.R. Part 2 and 45 C.F.R. §164.508. Only the above specified persons or agencies will receive this information. There are other special restrictions that apply to the release of information regarding, but not limited to, the reporting of HIV (F.S.A. §39.201), and elderly or disabled abuse (F.S.A. §415.1034). You have the right to inspect and/or copy protected health information to be used or disclosed as provided in 45 C.F.R. §164.524.

PROHIBITION ON REDISCLOSURE: This information has been disclosed from records whose confidentiality is protected. Federal and state rules prohibit anyone from making any further disclosure of this information unless the client provides specific written authorization for the subsequent disclosure of this information or as otherwise permitted by 42 C.F.R. Part 2 or F.S.A. §394.4615. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client (42 C.F.R. 2.32). Florida law requires that any person, agency or entity receiving this information shall maintain such information as confidential and exempt from the provisions of the public records laws (F.S.A. §394.4615(6)). Any facility or private mental health practitioner who acts in good faith in releasing information pursuant to F.S.A. §394.4615 or other Florida Statute is not subject to civil or criminal liability for such release.

I understand that this authorization for release of information shall be effective the date of signature and expire one year from the date of signature or at the time services are concluded if before one year. I also understand that I may revoke this consent or authorization at any time, providing I notify the program in writing to this effect. I understand that revocation has no effect on action previously taken and I understand Communities Connected for Kids will not be held liable for any information released prior to my revocation. I understand there is potential for information disclosed via the authorization to be potentially subject to re-disclosure by the recipient and no longer protected by the federal code. I understand treatment, payment, enrollment, or eligibility for benefits is or is not contingent upon authorization.

I hereby release Communities Connected for Kids and its employees from any and all liability that may arise from the release of information as I have directed.

(*Signature of adult client or parent/guardian of a minor*) (*Date*)

(*Signature of Witness*) (*Date*)