

**Authorization to Release/Obtain Information**

Phone: 727-524-4464 / Fax: 727-507-4856

Client Name:       DOB:

SSN:       Phone Number:

**I hereby give permission to Directions for Living to:**

Release/Provide Information to agency/person below:  Yes  No

Receive/Request Information from agency/person below:  Yes  No

Initial each one that applies:

\_\_\_\_ **Safe Harbor:** 14840 49th St. N., Clearwater, FL 33762 / P: (727) 464-8058 / F: (727) 453-7778

\_\_\_\_ **Public Defender's Office:** 14250 49th St. N., Clearwater, FL 33762 / P: (727) 464-6516 / F: (727) 464-6119

\_\_\_\_ **Operation PAR:** 6655 66th St. N., Pinellas Park, FL 33781 / P: (727) 545-7564 / F: (727) 545-7584

\_\_\_\_ **ACTS:** 3575 Old Keystone Rd., Tarpon Springs, FL 34688 / P: **(727) 935-0295 / F: (727) 934-0123**

\_\_\_\_ **Boley Centers:** 445 31st N., St. Petersburg FL, 33713 Phone / P: (727) 821-4819 / F: (727) 490-0538

\_\_\_\_ **Morton Plant Hospital:** 300 Pinellas St., Clearwater, FL 33756 / P: (727) 462-7500 / F: (727) 462-7654

\_\_\_\_**PEMHS:** 11254 58th St. N., Pinellas Park, FL 33782 / P: (727) 545-6477 / F: (727) 549-6074

\_\_\_\_ **Suncoast Center:** 4024 Central Ave., St. Petersburg, FL 33711 / P: (727) 327-7656 / F: (727) 322-2109

\_\_\_\_ **Bay Pines** **VA:** 10,000 Bay Pines Blvd., Bay Pines, FL 33744 / P: (727) 398-6661 / F: (727) 398-9543

\_\_\_\_ **Windmoor:** 11300 U.S. 19 N., Clearwater, FL 33764 / P: (727) 541-2646 / F: (727) 322-7205

\_\_\_\_ **Westcare:** 2525 1st Ave. S., St. Petersburg, FL 33712 / P: (727) 490-6768 / F: (727) 541-3993

\_\_\_\_ **St. Anthony’s Hospital:** 1200 7th Ave. N., St. Petersburg, FL 33705 / P: (727) 825-1100 / F: (727) 825-1344

\_\_\_\_ **Largo Medical Center:** 201 14th St. S.W., Largo, FL 33770 / P: (727) 588-5200 / F: (855) 446-6008

\_\_\_\_ **Pinellas County Health and Human Services**: 647 1st Ave. N., St. Petersburg, FL 33701 / P: (727) 464-4200 / F: (727) 464-8591

\_\_\_\_ **Community Health Centers of Pinellas:** 1344 22nd St. S., St. Petersburg, FL 33712 **/** P: (727) 824-8181 / F: (727) 824-8150

\_\_\_\_ **Pinellas County Health Departments:** 205 Dr. Martin Luther King Jr. St. N. Suite 2-173, St. Petersburg FL, 33701 / P: (727) 824-6900 / F: (727) 820-4163

**Other Agency or Person:**

**Address:**

**Phone #:**       **Fax #:**      

**The Specific Information to be disclosed is:** INITIAL each item - either written (W) or verbal (V) or both

W V Psychiatric Evaluation W V Bio-psychosocial Evaluation

W V Psychiatric Follow Up Notes W V Clinical Progress Notes

W V Lab, X-Ray, EKG, EGG, CT Scan W V Treatment Plan(s)

W V Medication List W V Psychological Testing

W V Drug/ Alcohol Treatment W V Treatment Summary

W V Appt. Scheduling/Re-Scheduling/ Confirmation W V Discharge Summary

W V Other (must specify):

**Date Range of Records to be Released**  All **OR** FROM (month/year): TO (month/year):

**Please make a selection:** Release Records Now **OR**  File until a Request for Records is Made

**Purpose of Release:** This information is being released, received, and used for the purposes of coordinating my care, evaluating my needs, and/or providing services to me. If other, please explain:

I understand that I have the right to refuse to sign this authorization and that my treatment is not contingent upon whether or not I 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, drug abuse, mental health, and HIV patient 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 Directions for Living cannot guarantee that subsequent re-disclosure will not happen. I hereby release the issuing Organization/person from any liability, which may arise as a result of the use of the information contained in the copies of records released, as a result of this authorization, if such information is later used to my detriment. **I understand that there are fees incurred to cover copy services**. I also understand I have the right to inspect or copy the health information disclosed.

**Duration of Authorization**: This authorization is **valid for one (1) year** after the date of my signature as it appears below **OR** **valid from**       to       . This authorization will become invalid upon my discharge from the agency. This authorization may be revoked at any time upon written notification by the signatory or client, but revocation has no effect on previously taken action.

**I have been offered a copy of this authorization.**

Signature of Client: Date:

Signature of Legally Empowered Representative: Date:

Relationship to Client:

Witness: (MUST be witnessed to be valid) Date: