Sandy Pines
Authorization for Release of Information

Patient/Resident:	DOB:	MR #:

Please check mark (X) the form in which information is to be released/obtained from: **X** VERBAL **X** WRITTEN **X** FAX* **X** EMAIL*

I hereby request and authorize (name of provider/organization) **Sandy Pines** to release/obtain the following information from my medical record: Discharge Summary ___ Psy Evaluation ___ H/P___ Treatment Plans ___ LABS ___

Other **Any records requested for continued care.** (be specific - "All Medical Records" is not sufficient):

This information is to be released to and/or obtained from:

Name of Organization/Provider: ________________________________ Phone #: ____________________

Address: ____

Fax #: _____________________________ Email address: ______________________________________

This release will cover treatment service dates from_______________ to _____________ **Or one year from admission.**

The purpose of releasing/obtaining this information is for: **Continued Care**

Please note: only minimally necessary information will be released

Any release of mental health and substance abuse information must be pursuant to F.S.A. §394.4615, 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. §384.25), child abuse (F.S.A. §39.201), and 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 patient and/or guardian 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 patient. (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 law. (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.

If this authorization releases protected information to a third party payor, it is understood that payment may result.

* I understand by approving the release of information in the form of a facsimile (FAX), confidentiality cannot be assured. My initials indicate that I accept the risks that confidentiality may be breached when FAXING information. Resident or Rep. initials (__________)

* I understand by approving the release of information in the form of electronic records (EMAIL), confidentiality cannot be assured. My initials indicate that I accept the risks that confidentiality may be breached when EMAILING information. Resident or Rep. initials (__________)

I understand that this authorization will expire 1 year from the date of my signature below. I understand that I have the right to refuse to sign this Authorization and that treatment will not be withheld on condition that I sign this form. I further understand that I may revoke my consent by completing the bottom of this authorization at anytime prior to the release of any information. I understand Sandy Pines will not be held liable for any information released prior to my revocation.

I will be offered a copy of this Authorization for Release of Information and may request a copy of this Authorization at any time.
I hereby release Sandy Pines and its employees from any and all liability that may arise from the release of information as I have directed.

______________________________	______________________________	____________
Signature of resident (If applicable)	Print name	Date
Signature of parent/representative	Print name	Date
Witness signature	Print name	Date

☐ Guardian ☐ Guardian Advocate ☐ Health Care Proxy ☐ Personal Representative

SIGNATORY REVOCATION

______________ (initial and date above)	I hereby **REVOKE** my permission to release and/or request information from my medical record to the Person or Organization noted on this form.

Revised 04/16