

Behavioral Health

**AUTORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient’s Name: ­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Name: 

I request and authorizeto release healthcare information for the patient named above to:

Name:

Address:



This request and authorization applies to:

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Healthcare information relating to the following treatment condition, or dat

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|  |

All healthcare information

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Other:

This authorization expires or 6 months from the date this document is signed. IF the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, true Information refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment to your eligibility for benefits. You may inspect or copy the protected health information to be used or disclosed under this authorization. Finally, you may revoke this authorization in writing at any time by sending written notification to [ name of Privacy contact] at [office address]. Your notice will notapply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

My protected health information will be used or disclosed for the following purpose(s)

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Yes, I authorize the release of any records regarding drug, alcohol, or mental health treatment to be the

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|  |

No person(s) listed above

Patient or personal Representative Signature: Date:

Print name:

Description of Personal Representatives Authority/

My protected health information is Individually health information. Including demographic Information, collected From me or created or received oy a health care provider, a health plan, my employer, or a health care clearing house and relates to : (i) my past, present or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, or future payment for the

provision of health care to me.

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