Authorization For Release Of Information

Client: ___________________

I hereby authorize Meridian Behavioral Healthcare, Inc. to: ☐ **Release AND/OR** ☐ **Receive the following** (Check all that apply):

☐ Treatment Goals and Progress ☐ Evaluations and Assessments ☐ Information Concerning AIDS/HIV Infection
☐ Educational Information ☐ Medical/Psychiatric Assessment & Treatment (Including Labs and Medications)
☐ Behavioral Observation ☐ Substance Use/Abuse Assessment & Treatment (Including Labs and Medications)
☐ Therapy/Counseling Notes ☐ Other (Specify):_____

In compliance with FS 90.503, 394.459(9), 394.4615, 395.3025(2)(3), 397.501(7), and Federal Regulations 45 CFR, Part 164.508 (c)(1) & 42 CFR Part 2.

Information from the records of:

Name:
Address:
City:
State: **Zip Code:**
Date of Birth:
S.S #:
Telephone Number:

TO/FROM: Please check all that apply:

☐ **Partnership for Strong Families**
☐ **Department of Children & Families**
☐ **Social Security Administration**
☐ **State Attorney**
☐ **Probation/Parole**
☐ **Personal Attorney**
☐ **Other**
☐ **Other**
☐ **Other**
☐ **Other**

For the purpose of (check one) ☐ to assist in the evaluation and treatment of the client. ☐ other (specify):

This release form shall be valid for (check one):

☐ A single disclosure OR ☐ A continuing disclosure for 90 days from signature date below.
☐ A continuing disclosure for 1 year from signature date below.

- I acknowledge that I have read, or have had read to me, this authorization and fully understand its contents. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- I understand that if the person or organization that receives this information is not a health care provider or plan covered by Federal Privacy Regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.
- I understand that unless otherwise limited by state or federal regulations and except to the extent that information has been released based on my prior authorization, I may revoke this authorization at any time by writing to the Health Information Management department at the organization named above.

_______________________________ Date _____________________
Signature of Client

_______________________________ Date _____________________
Signature of Legal Guardian or Parent

_______________________________ Date _____________________
Printed Name of Legal Guardian or Parent

____
Relationship

_______________________________ Date _____________________
Witness

PROHIBITION OF RE-DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of medical or other information is not sufficient for this purpose.

PLEASE RETURN INFORMATION TO:
Meridian Behavioral Healthcare, Attn: __________________ 4300 SW 13th Street, Gainesville, Florida 32608