AUTHORIZATION FOR RELEASE OF INFORMATION

CHART # _____

Information from the records of:

_____
Client Name

_____
Address

_____
City/ State/ Zip

_____
Date of Birth / Social Security Number

_____
Telephone Number

TO/FROM:

_____
Release to Name

_____
Organizations Name

_____
Address

_____
City/ State/ Zip

_____
Telephone Number

_____
Fax Number

_____
Email

Information from: __/__/__ to __/__/__

I hereby authorize Meridian Behavioral Healthcare, Inc. to (check one): ☐ **Obtain** ☐ **Release** ☐ **Exchange**

the following ☐ **written** ☐ **verbal** ☐ **electronic** (***Check all that apply***):

☐ Treatment Plan/ Status Report ☐ Evaluations and Assessments ☐ Inpatient Substance Use Treatment

☐ Inpatient Psychiatric Treatment ☐ Primary Care ☐ Therapy/Counseling Notes

☐ Outpatient Psychiatric Treatment (Including Labs and Medications) ☐ HIV/AIDS Information

☐ Outpatient Substance Use Treatment (Including Labs and Medication) ☐ Other (Specify):_____

For the purpose of (check one):

☐ Continuity of Care. ☐ 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.

To Receiving Agency:

PROHIBITION OF RE-DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further disclosure is strictly prohibited unless the client provides specific written consent for the subsequent disclosure of this information. A general authorization for the release of medical or other information is not sufficient to waive confidentiality of these records.

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.

_____ _____
Signature of Client Date

_____ _____
Signature of Legal Guardian or Parent Date

_____
Printed Name of Legal Guardian or Parent

_____
Relationship

_____ _____
Witness Date

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. ***A signed revocation may be submitted at any time, but Meridian Behavioral Healthcare, Inc. shall not be held liable for any information released prior to its receipt. Information disclosed under this authorization might be redisclosed by the recipient and this redisclosure may no longer be protected by federal or state law. Your signature on this authorization is not required to receive treatment.***

PLEASE RETURN INFORMATION TO: Meridian Behavioral Healthcare, Attn:HIM Department 4300 SW 13th Street, Gainesville, Florida 32608 Fax: 352-244-0289

MBH Form #207 – Attachment A
Created 02/87, Revised: 6/03, 7/04, 11/10, 02/11, 7/12, 7/17