NOTICE OF PRIVACY PRACTICES

IMPORTANT: THIS NOTICE DESCRIBES YOUR HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND EXPLAINS YOUR PRIVACY RIGHTS AS A CLIENT OF MERIDIAN BEHAVIORAL HEALTHCARE CENTER, INC. AND. PLEASE REVIEW THIS NOTICE CAREFULLY AND LET YOUR SERVICE PROVIDER KNOW IF YOU HAVE ANY QUESTIONS.

The terms of this Notice of Privacy Practices apply to all services performed by Meridian Behavioral Healthcare Center, Inc. and are effective October 1, 2018. This organization and its employees will share individual patient health information as is necessary to provide quality health care and receive reimbursement for those services as permitted by law. This agency is required by law to maintain the privacy practices with respect to your individual health information. We reserve the right to change the terms of this Notice of Privacy Practices as necessary. A copy of any revised notices will be available in this office, or, upon written request to 4300 SW 13th Street, GAINESVILLE, FLORIDA, 32608. A copy may be picked up at this address, within 15 days of the request.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Except as described below, this agency will maintain the confidentiality of your individual health information. Your individual health information may be used and disclosed as customary and reasonable for purposes of treatment, payment and healthcare operations. For all other uses except for those required by the Department of Children and Families or the Partnership for Strong Families or certain other State and Federal agencies, we must have a signed authorization form permitting any other use or disclosure. You have the right to revoke that authorization in writing unless any action has been taken in reliance on the authorization.

TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Except as limited by State and Federal privacy laws, or with your signed consent, this agency will use your individual health information as necessary for purpose of your treatment, payment and as necessary for our health care operations which include clinical improvement, professional peer reviews, business management, accreditation and licensing, as permitted by law.

FAMILY AND FRIENDS

With your written signed permission, and subject to the best judgment of Meridian, your individual health information may be disclosed as designated by you to family, friends or others who are involved in your care or in payment of your care. If you are incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited health information with such individuals without your permission.

BUSINESS ASSOCIATES

At times it may be necessary for Meridian to provide some of your health information to certain outside persons, organizations or agencies that assist us with our health care operations, our auditing, our accreditation, necessary legal services, computer hardware and software and other kinds of business operations. These business associates are required by a written agreement with Meridian to properly safeguard the privacy of your information and to report to Meridian any breaches of privacy which may occur to or through the business associates.

APPOINTMENTS AND SERVICES

This agency may contact you to provide appointment reminders or information about your treatment alternatives or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you, to receive communications regarding your individual health information from us by alternative means or at alternative locations. You may request such confidential communication in writing and may send your request to 4300 SW 13th Street, GAINESVILLE, FLORIDA, 32608.

OTHER USES AND DISCLOSURES

Other uses and disclosures of your individual health information, permitted or required by law, may be made without your consent or authorization but after you have been notified of any of the following:

- Release of your health information for any purpose required by law, including but not limited to court order after notice, a subpoena after notice or at the direction of State or Federal agency with authority;
- Release of your individual health information for public health activities, such as required reporting of disease, injury, birth, death and for required health investigations;
- Release of your individual health information as required by law if we have good reason suspect child, elderly or disabled abuse or neglect of or by you or someone with whom you are associated;
- Release of your individual health information as required by law if we believe you to be the victim of abuse, neglect or domestic violence;
- Release of your individual health information to Food and Drug Administration if necessary to report adverse events, product defects or to participate in product recalls;

- Release of your individual health information if required by law to a government oversight agency conducting audits, investigations or civil or criminal proceedings;
- Release of your individual health information if required to do so by a court or administrative ordered subpoena or discovery request;
- Release of your individual health information to law enforcement officials as required by law to report wounds and injuries and crimes or for purposes of identification;
- Release of your individual health information to coroners and/or funeral directors consistent with law;
- Release of your individual health information to workers' compensation agencies if necessary for your workers' compensation benefits determination.

YOUR RIGHTS

ACCESS TO INDIVIDUAL HEALTH INFORMATION

You have the right to inspect the record of your individual health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. We will charge you a fee of a $1.00 per page for the first 25 pages and $.25 for every page after 25. We will also charge for postage if you request a mailed copy and will charge for preparing a summary of the requested information of you request such a summary. You may obtain an access request form from our Health Information Management department at 4300 SW 13th Street, GAINESVILLE, FLORIDA, 32608.

AMENDMENTS TO INDIVIDUAL HEALTH INFORMATION

You have the right to request in writing that individual health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments, but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction you request is made by us, we may also notify others who work with us, if we believe that such notification is necessary. You may obtain an amendment request form from our Health Information Management department at 4300 SW 13th Street, GAINESVILLE, FLORIDA, 32608. If your request is denied, you have a right to submit a writing to Meridian which will be included in your individual health information showing your request for amendment and the denial of it.

ACCOUNTING FOR DISCLOSURES OF INDIVIDUAL HEALTH INFORMATION

You have the right to receive an accounting of certain disclosures made by us of your individual health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. Accounting request forms are available from our Health Information Management department at 4300 SW 13th Street, GAINESVILLE, FLORIDA, 32608. The first accounting in any 12-month period is free; you will be charged a fee of $2.00 for each subsequent accounting you request in a 12-month period.

RESTRICTIONS ON USE AND DISCLOSURE OF INDIVIDUAL HEALTH INFORMATION

You have the right to request certain restrictions on certain of our uses and disclosures of your individual health information. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate and agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to our Health Information Management department at 4300 SW 13th Street, GAINESVILLE, FLORIDA, 32608. If you or someone on your behalf requests a restriction asking that we do not disclose a particular care or treatment to a health plan and you document that all charges for the care and treatment have been paid for by you, we will honor that request.

COMPLAINTS

If you believe your privacy rights have been violated, you can file a complaint with our Corporate Compliance Officer located at 4300 SW 13th Street, GAINESVILLE, FLORIDA, 32608. You may also file a complaint in writing within 180 days of a violation of your rights with the US Department of Health and Human Services Office of Civil Rights by sending a letter to 200 Independence Avenue SW, WASHINGTON, DC 20201; by phone calling 1.877.969.6775; or online by visiting www.hhs.gov/ocr/privacy/hipaa/complaints. There will be no retaliation for filing a complaint.

If you have any questions or need additional assistance regarding this Notice, you may contact our Corporate Compliance Officer, Kimberly Abbott, Sr. Vice President of Human Resources, by mail: 4300 SW 13th Street, Gainesville, Florida 32608; phone: 352.374.5600; fax: 352.371.9841; or e-mail: Kimberly_Abbott@mbhci.org.

WELCOME TO MERIDIAN BEHAVIORAL HEALTHCARE, INC.

Your Rights and Responsibilities

Helping us to better serve you

MERIDIAN'S RESPONSIBILITIES

As a person served by Meridian Behavioral Healthcare, Inc., you have a right to be treated with dignity, gentleness, courtesy, and respect. Meridian staff are dedicated to providing the best possible treatment and services while you participate in our programs. It is every employee's responsibility to ensure Meridian conducts business in a legal and ethical manner, consistent with federal and state regulations and statutes, as well as ethical standards of the professions represented by Meridian's staff.

MISSION & PHILOSOPHY OF CARE

Meridian believes you deserve to be treated with respect and empowered to direct the care you receive. Care is delivered in a coordinated and culturally competent manner by professionals best suited to meet your needs. Services are provided in the least disruptive manner, consistent with your lifestyle, with the goal of increasing the quality of your life in the community of your choice. Toward these ends, Meridian delivers a range of individualized services designed to facilitate your recovery and resilience using best clinical practices. Key goals are enhancing your motivation to learn and modify behaviors that support the highest quality of life possible for you and your family.

NON-EMERGENCY SERVICES

Meridian offers a variety of treatment and educational services to assist you and your family to resolve problems and promote health, growth, and development. Professional services combine assessment, counseling, therapy, and education, and include medication evaluation and management, individual, family, and couples counseling, as well as groups. Each counselor or case manager schedules appointments in an effort to accommodate your needs. Our business offices are open Monday-Friday from 9:00 a.m. until 5:00 p.m.

REFERRAL & EMERGENCY SERVICES

The Access Center at Meridian is your single point of contact for information, referral, and emergency services 24 hours/day, 7 days/week. Reach Access Center at the numbers listed here. On-demand services available through Telehealth and walk-in.

YOUR RIGHTS WHILE RECEIVING SERVICES

As a recipient of services, you have the right to:

- Be treated with respect at all times
- Be free from abuse, financial or other exploitation, retaliation, humiliation, and neglect
- Appropriate treatment, regardless of your ability to pay
- Receive treatment in the least restrictive setting
- Informed consent or refusal or expression of choice regarding service delivery, concurrent services, composition of service delivery team, release of information, and involvement in research projects
- Be informed about the reason for your admission, proposed treatment, potential side effects of treatment, approximate length of stay, and other possible treatments
- Take back any consent to treatment either in writing or verbally by you, your guardian, or guardian advocate
- Access or referral to legal entities for appropriate representation
- Be appointed a guardian advocate through the court, if needed, to make decisions regarding your treatment
- Receive services that are timely, skillfully, safely, and humanly administered
- Receive appropriate medical, vocational, social, educational, and rehabilitative services
- Have reasonable access to your own records
- Authorize release of information to people or agencies
- Have your records kept confidential
- Designate a person to receive any required notices
- Help make decisions about your treatment and provide written comments on your treatment plan
- Help make plans for your discharge
- Have access to self-help and advocacy support groups
- Adherence to research guidelines and ethics when involved in research projects
- A reasonable measure of privacy and protection of your constitutional rights, including right to legal counsel
- Confidentiality in your communication with Meridian and its employees
- A treatment environment that prioritizes equality, diversity, and openness

YOUR RIGHTS WHILE IN RESIDENTIAL SERVICES

- Access a private telephone to report any possible abuse or neglect to the Florida Abuse Hotline
- Written inventory of any of your personal clothing or belongings that are taken from you
- Assistance in registering to vote and voting
- Question the cause and legality of your being detained (Habeus Corpus)
- Have visitors at reasonable hours within program guidelines, unless restricted as a part of your treatment
- Access to mail and telephone services in accordance to program guidelines, unless restricted as part of your treatment
- Have personal clothing and belongings, unless restricted as a part of your treatment
- A private space in which to keep your personal clothing and other property
- Three balanced meals per day, plus a snack
- Use of private toilet and bathing facilities
- Access to social and recreational activities
- Opportunities for religious worship
- Children have the right to receive education as appropriate in least restrictive setting possible

CONFIDENTIALITY OF RECORDS

Federal law requires your Meridian treatment record be confidential. Meridian staff are not allowed to tell anyone outside the agency that you receive services, or that you suffer from a mental illness/substance use disorder, unless one or more of the following is true:

- You consent in writing
- Disclosure complies with a court order
- Disclosure is made to medical personnel in a medical emergency
- Disclosure is made to qualified personnel for research purposes
- Disclosure is part of an audit or program evaluation, including approved peer and utilization reviews of service records
- Your safety or that of others is at significant risk and disclosure of some information is required for your protection or the protection of others
- Disclosure involves information reported under state law to appropriate state or local authorities about suspected abuse or neglect of a child or elderly or disabled person
- Information is about a crime committed by you, either at Meridian or against any person who works for Meridian, or any threat to commit such a crime.

Violation of federal law by Meridian is a crime. Suspected violations may be reported to appropriate authorities.

YOUR RESPONSIBILITIES

In order for Meridian Behavioral Healthcare to provide the best possible service during your treatment, it is important that you:

- Actively and earnestly participate in developing the plan for your treatment and follow that plan
- Follow these and other program rules in order to protect your safety and the safety of others
- Respect others' privacy and confidentiality
- Be courteous and respectful
- Smoke or use tobacco products only in designated areas off Meridian premises
- Do not use inappropriate verbal or sexual behaviors
- Do not use verbal or physical aggression
- Do not bring weapons or sharp objects on the premises
- Keep medication (including over-the-counter) in a safe, secure place while on the premises
- Do not use or bring alcohol or illegal substances on the premises
- Do not loiter or sleep in the buildings or on the premises
- Do not sell, loan, borrow or steal items
- Place clutter and trash in proper containers
- Keep scheduled appointments, or cancel at least 24 hours in advance
- Pay for treatment when services are rendered or in accordance with your agreement with Meridian
- Provide full information regarding any treatment you are receiving or have received in the past, including all types of counseling/therapy, medications and/or hospitalizations
- Allow staff in residential programs to conduct searches necessary to ensure the safety of everyone in the program

ADVANCED DIRECTIVES

You have the right to give written instructions called Advanced Directives when you receive services from Meridian. Advanced Directives allow you to state your preferences for future care, should you be unable to communicate your decisions or preferences for mental health treatment.

Advanced Directives may include a living will, power of attorney, or other care instructions. Before deciding to have Advanced Directives, you should discuss the matter thoroughly with family members, your doctor, and your counselor and/or case manager.

SATISFACTION WITH SERVICES & SPECIAL NEEDS

We work hard to make you comfortable at Meridian and we want you to be satisfied with the services you receive. If there is ever something that does not meet your expectations or you have a special need, discuss it with the staff assigned to your care.

You have the right to file a Concern Reporting/ Accommodation Request as a formal notice of dissatisfaction with services or staff, or to request any special help you need to fully participate in the services offered by Meridian. The program supervisor will assist you in resolving your issues and/or accommodating your request. If you feel that further assistance is needed, you may have your concerns reviewed by the administrative staff.

Any staff member can help you fill out this form, if assistance is needed. After you put your concern/ request in writing, give the form to any Meridian employee. It will immediately be forwarded to the Office of Quality Improvement.

Your concern or request will be reviewed and a supervisor will contact you to discuss solutions to the issue within ten days. If you are still dissatisfied, other administrators will be asked to meet with you until an agreeable solution is found.

Meridian is continuously trying to improve the effectiveness of its services and how we deliver services. The most important information we receive is from the people we serve; therefore, we receive information from you in the following ways:

- Your participation in bi-annual consumer satisfaction surveys and follow-up surveys after discharge
- Review of your concerns and feedback regarding services or service delivery
- Customer participation in initiatives and activities for Meridian's Stakeholders Relations Committee
- Staff reporting of unusual incidents at Meridian
- Your meetings with staff regarding progress in meeting treatment or service objectives

IMPORTANT CONTACT INFORMATION & PHONE NUMBERS

Meridian Behavioral Healthcare, Inc.

Emergency Services Information & Referral

24 hours/day, 7 days/week

352-374-5600 (Local)
1-800-330-5615 (Toll Free)

www.mbhci.org
Walk-Ins & Telehealth available

Florida Relay Service
1-800-955-8770 (Voice)
1-800-955-8771 (TTY)

Human Rights Advocacy Committee
1-800-342-0825 (Toll Free)
1-800-955-8771 (TTY/TDD)

Florida Abuse Hotline
1-800-962-2873 (Toll Free)
1-800-453-5145 (TTY/TDD)

Advocacy Center for Persons with Disabilities
1-800-342-0823 (Toll Free)
1-800-346-4127 (TTY/TDD)

Local State of Florida Substance Abuse & Mental Health Office
904-485-9583

MERIDIAN

Meridian Behavioral Healthcare, Inc.

Partially funded by LSF Health Systems, LLC, and the State of Florida Department of Children and Families

Consent for Treatment

Client: _____

Consent

_____ (the "Patient" or the "Legal Representative or Agent of the Patient") by signing this three-page form:

1. I apply for and consent to such medical or psychiatric care, including counseling by non-physician professional staff of Meridian Behavioral Healthcare, Inc. ("Meridian") which care may include prescription of medications, diagnostic tests and in-patient and out-patient care and treatment for me or for the minor child or other person for which the legal representative or agent is signing;

2. I consent to the use or disclosure of any Protected Health Information ("PHI") by Meridian for the purpose of medical or psychiatric care, for the purpose of counseling or for the payment for services provided by Meridian in accordance with all state and federal privacy laws as described in the Notice of Privacy Practice which has been furnished to me;

3. I understand that any alcohol or drug treatment records are protected under specific Federal regulations governing confidentiality of alcohol and drug abuse patient records which records cannot be disclosed without my written consent unless disclosure is otherwise provided for in Federal regulations;

4. I understand that all of my records with Meridian are protected under the Federal Privacy Regulations within the Health Insurance Portability and Accountability Act ("HIPAA") and under the Health Information Technology for Economic and Clinical Health ("HITECH");

   4.a. In addition, I understand that I may be asked to release information to myHealthStory for the purpose of receiving healthcare and the coordination of my care by my Providers. Should I wish to receive this coordination of care, I understand a special Health Information Exchange Release will be provided to me so that I may authorize Meridian to share my information with my other Providers.

5. The recipient of such information which is disclosed may re-disclose the information and it may no longer be protected by the privacy laws.

6. I consent to receive a follow-up call for up to 18 months after completion of any treatment by Meridian.

Payment For Services

By signing this form, I express my understanding that I am obligated to pay for all services provided by Meridian which are not paid for by any available insurance benefits which may aid in the payment for services. I acknowledge that if I lose insurance eligibility or if coverage is denied or reach benefit maximum, I am fully responsible for all of the fees charged by Meridian.

1. I am responsible for any deductible and any co-pays based on the specific insurance plan;
2. If insurance that provides coverage for me is not available for care by Meridian, it is my responsibility to verify what services by Meridian will be covered and obtain authorization for those services. I accept that I am responsible for any charges not covered by insurance;
3. I agree to contact Meridian and provide notice to Meridian at least 24 hours in advance of any cancellation of appointment or my being unavailable to keep an appointment. I understand that if such notice is not furnished, a charge of $25.00 for a missed appointment will be assessed;
4. I understand that if I am a MEDICAID recipient, I am responsible to pay a maximum of a $2.00 co-pay based on the specific MEDICAID plan, my age or any disability status;
5. I understand that if I am a participant in MEDICAID SHARE OF COST, then I will be charged an assessed fee until becoming eligible for MEDICAID coverage in any given month at which time Meridian will bill MEDICAID for services. All services received before becoming eligible for MEDICAID are my responsibility. I understand that it is my responsibility to provide proof of expenses to the local MEDICAID/DCF Office each month;
6. If I am a MEDICARE beneficiary, I am responsible for all deductibles and co-pays as set by MEDICARE. MEDICARE fees are subject to change based on my individual coverage or changes in the MEDICARE policy. Physicians, nurses and other therapists at Meridian who are enrolled as MEDICARE Providers accept assignment (which means I pay the co-pay and Meridian bills MEDICARE as payment in full). I understand that some Meridian therapists are not enrolled as

MEDICARE providers. If I choose to receive clinical services from a provider who is not enrolled as a MEDICARE provider, I am responsible for the fees charged.

7. I understand that if I am eligible for self-pay/sliding fee scale which Meridian offers to uninsured individuals, that my fee will be based on my income and family size. Additional discounts may be offered to me if I can document a situation of financial hardship. Discounts based on hardship are evaluated on a case-by-case basis.

Family Income Information

TOTAL in HOUSEHOLD #
List ALL Household Family Members

Last Name	First Name	DOB	Age	Relationship to Client
				Client

Source of Income	Annual Amount	Last 30 Days
Employment Income	$	$
Social Security Income	$	$
State AID- SSI, AFDC, Medicaid	$	$
Food Stamps	$	$
Pension Income	$	$
Workers Comp Income	$	$
Unemployment Income	$	$
Child Support/Alimony	$	$
Money from Family Member/Other	$	$
Other Income	$	$
TOTAL Annual	$	----------
TOTAL Last 30 Days	----------	$

County of Residence:
Third party / COBRA assistance - If unemployed and you were previously covered by Health insurance? Yes ☐ or No ☐
Date of last worked day
Have you applied for Medicaid or county assistance? Yes ☐ or No ☐ If yes, when and where?
Have you applied for WIC/food stamps? Yes ☐ or No ☐ If yes, when and where?
Have you applied for social security disability (SSI/SSD)? Yes ☐ or No ☐ If yes, when and where?

Consent for Treatment

Client: _____

INSURANCE BENEFIT DETERMINATION AND ESTIMATED OUT-OF-POCKET EXPENSE				
Service Location	**Substance Abuse Benefits**	**Mental Health Benefits**	**Deductible/Coinsurance**	**Copayment**
Inpatient				
Outpatient				
Intensive Outpatient				

Questions About Billing, Charges Or Fees

If I have any questions about the requirements or payment for services or the fee determination of the insurance benefits determination, I can call the Meridian Finance and Accounting Department which is available to assist me with any questions or information during regular business hours by calling: 352-374-5600, Extension 8323.

Authorization For Insurance Billing

A Financial Counselor or other knowledgeable person with Meridian has explained any insurance benefits that are available to me. I authorize Meridian to contact any insurance company with which I may have benefits to obtain an explanation of my benefits. I understand that I am responsible for charges not paid by any available insurance coverage or available benefits from MEDICARE. I understand it is my responsibility to pay any out-of-pocket expenses in full or make arrangements for payments before discharge. Any arrangement for payment will be through a promissory note or other financial document. In addition to authorizing insurance billing, I understand and accept responsibility that Meridian may exercise its rights to collect from me all charges I owe and whatever amount for which I have provided a promissory note. I recognize that there may be collection charges and legal fees for collection efforts.

Termination of Care for Non-Payment

By signing this Professional Services Agreement, I acknowledge that Meridian has the right to terminate treatment and refer me elsewhere for continuing care if I have an unpaid balance with Meridian exceeding $500. I understand that I may be allowed to defer payment for a maximum of two out-patient sessions after which no further services will be provided. Unless prior arrangements have been made, I understand that treatment may be terminated at any time if payments have not been made as agreed. Any such termination will be consistent with requirements governing various therapists who may provide care.

Termination of Care for Missed Appointments

By signing this Professional Services Agreement, I acknowledge that should I fail to keep two consecutive appointments within a 30-day period, a scheduling lock will be placed on my account and I can be discharged from Meridian programs. I also understand that in order to resume services, I must contact the Program Director (of the Program I want to resume) and request readmission.

Signature of Patient or Legal Representative or Agent of Patient	
Description of the Kind of Representative or Agency Status (Parent, Legal Guardian, Next of Kin, Health Care Surrogate)	
Witness to Signature of Patient or Legal Representative or Agent	

Telemedicine Services Consent Form

Client: _____

Informed Consent for Telemedicine Services

- I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.
- I understand that the telemedicine visit will be done through a two-way video link-up. The healthcare provider will be able to see my image on the screen and hear my voice. I will be able to hear and see the healthcare provider.
- I understand that the laws that protect privacy and the confidentiality of medical information including (HIPPA) also apply to telemedicine.
- I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.
- I understand that I am responsible to have a private setting for my telehealth sessions and to disclose if anyone else is in the room or listening in on the telehealth session.
- I understand that if the treating professional determines that telehealth is not appropriate, he/she will work with me to arrange other services.
- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without effecting my right to future care or treatment.
- I understand that by signing this form that I am consenting to receive health care services via telemedicine.

Client Signature:

_____

Printed Name

_____

Signature/Date

Parent/Guardian Signature:

_____

Printed Name

_____

Signature/Date

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