APALACHEE CENTER, INC.
AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

Client Name: _____ *Program:* _____ *Client #:* _____
Last *First* *M.I.*

AKA: _____ *SSN:* [redacted]-[redacted]-[redacted] *DOB:* ___/___/___

(Please call if complete # required for ID purposes)

THIS WILL AUTHORIZE *(Specify Agency or Representative):* **APALACHEE CENTER, INC.**

(Address) **2634 CAPITAL CIRCLE N.E. ; TALLAHASSEE, FL 32308**

To disclose the following specified medical, mental health, alcohol and/or drug abuse treatment information. The release of available third-party information (i.e., records received from other providers) or information concerning AIDS/HIV tests, counseling and the results and treatment thereof is authorized unless otherwise specified. The releasing agent is authorized to act on behalf of a copy/facsimile of the original form unless otherwise specified under Restrictions line below.

INFORMATION REQUESTED (✓) Note: *Only the most recent edition/form will be sent unless a time frame is specified:* __/__/__ - __/__/__

- ☐ INTAKE / PRELIMINARY ASSESSMENT
- ☐ PSYCHOSOCIAL HISTORY
- ☐ PSYCHOLOGICAL EVALUATION / SUMMARY
- ☐ PSYCHIATRIC EVALUATION
- ☐ HISTORY & PHYSICAL EXAM
- ☐ NURSING ASSESSMENT
- ☐ MEDICAL QUESTIONNAIRE
- ☐ LAB / EKG REPORTS
- ☐ TREATMENT PLAN
- ☐ DISCHARGE INSTRUCTIONS/ SUMMARIES
- ☐ MEDICATIONS LIST
- PROGRESS NOTES: __/__/__ - __/__/__ *(Select Below)* *(Time frame required)*
  - ☐ Inpatient Psychiatric / Medical / SS
  - ☐ Outpatient Psychiatric / Medical

( ) OTHER INFORMATION *(must describe):* _____

DO NOT RELEASE THE FOLLOWING INFORMATION: ☐ N/A _____

THIS INFORMATION IS TO BE RELEASED / SENT TO *(Agency Name):* _____

Program or Representative's Name (please include on return envelope) & Phone #: _____

Mailing Address: _____

FOR THE PURPOSE OF: *( ) Coordination of Treatment/Continuity of Care; ( ) Legal Issues; ( ) Personal; ( ) Other:* _____

THIS INFORMATION MAY BE REVIEWED OR RELEASED *Verbally/Orally, via Copies (i.e., Xerox), Electronically (i.e., computer), or by Fax unless restricted below:*

RESTRICTIONS ON USE/RELEASE OF INFORMATION: ☐ N/A _____

THIS AUTHORIZATION IS in effect for one year after the initial date or renewal date, or from ___/___/___ to ___/___/___, or upon _____.

The specified information may be exchanged between the above designated authorized agencies or representatives unless otherwise restricted above. This authorization may be revoked at any time upon verbal or written notification by the client or authorized representative, but revocation has no effect on action previously taken. I understand Apalachee may only condition treatment on obtaining this signed authorization when providing services solely for the purpose of creating information for disclosure to a third party and this authorization is for disclosure to that third party. I understand that information disclosed to non-healthcare providers (or entities not governed by applicable law) may no longer be protected by Federal privacy regulations upon release by Apalachee Center.

_____	___/___/___	___/___/___	_____
*Signature of Client:**	*Date*	*Renewal Date*	*Initials*
_____	___/___/___	___/___/___	_____
*Signature of Guardian or Representative:**	*Date*	*Renewal Date*	*Initials*
_____	___/___/___		
Witness Signature	*Date*		

For releasing records relating to a minor between the ages of 12-18, the signatures of both the minor and legal guardian / representative are necessary.

PROHIBITION ON REDISCLOSURE OF INFORMATION PERTAINING TO ALCOHOL AND DRUG ABUSE RECORDS:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Cancellation / Revocation of Authorization:

___/___/___	_____	_____
Date	*Nature of Request*	*Staff/Witness Signature*