

## Authorization to Use and Disclose Protected Health Information

Patient's Name: \_\_\_\_\_ Dates of Treatment to Disclose: \_\_\_\_\_  All Dates

Address: \_\_\_\_\_  
 (Street) (City) (State) (Zip)

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**I acknowledge and hereby consent to release information from my health record including psychiatric and alcohol/drug abuse treatment information. I understand that the information in my health record may include information relating to sexually transmitted disease, HIV or AIDS. I understand that my records are protected under Federal and State regulations governing the confidentiality and privacy of health information under CFR 45, CFR 42 Part 2, FS 394, 397, 381 and 90.503 cannot be disclosed without my written authorization unless provided for by the regulations.**

**Please check the information you want disclosed:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Discharge/Continued Care Summary | <input type="checkbox"/> Psychiatric Evaluation        | <input type="checkbox"/> Medication Eval/History & Physical |
| <input type="checkbox"/> Labs & X-Ray Results             | <input type="checkbox"/> Psychosocial Assessment       |   |
| <input type="checkbox"/> Dates of Treatment Letter        | <input type="checkbox"/> Other (Please specify): _____ |   |

**I authorize Gracepoint to make disclosure to the individual or organization identified below:**  
 (RELEASE TO) (RECEIVE FROM) (EXCHANGE WITH)  
 ----- Please circle one of the above -----

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Type of Disclosure:**  Written  Verbal  Fax  Electronic

**The information that I am authorizing for disclosure will be used for the following purpose:**

- Continuity of Healthcare Treatment
  Education
  Insurance/Disability
  Legal Reasons
  My Personal Records

**This consent will expire on the following date, event or condition:** \_\_\_\_\_

**If I fail to specify an expiration date, event or condition, this authorization will automatically expire one year from the date signed**

I understand the type of disclosure(s) authorized may be released past the date I sign until the expiration date of this authorization.

**I understand that:**

- I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing at:
  - 2815 East Henry Ave., Suite D7, Tampa, Florida 33310 (I understand that the revocation will not apply to information that has already been disclosed in response to this authorization).
- If the requester or receiver is not a health plan or healthcare provider, then the disclosed information may no longer be protected by Federal Privacy Regulations and may be re-disclosed.
- I am entitled to receive a copy of this authorization.
- I may refuse to sign this authorization, and my refusal to sign will not affect my ability to obtain treatment, payment or eligibility for benefits.
- I hereby release Gracepoint from liability which may arise as a result of information disclosed under this authorization if such information is later used to my detriment.

**Signature of Patient/Guardian/Representative (circle one):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Patient's Legal Representative (if applicable):** \_\_\_\_\_ **Date:** \_\_\_\_\_

If signed by Legal Representative, Relationship to the patient: \_\_\_\_\_

Proper documentation establishing relationship is provided (specify documentation): \_\_\_\_\_

**Signature of Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**2815 East Henry Avenue – D7, Tampa, Florida 33610: PHONE: (813) 239-8279; Release of Information FAX: (813) 239-8397**