WINDMOOR HEALTHCARE
11300 U.S. Hwy 19 North Clearwater, FL 33764
(727) 541-2646 FAX: (727) 322-7205

AUTHORIZATION TO RELEASE AND EXCHANGE PROTECTED HEALTH INFORMATION

Patient Name:_____ **Date of Birth:**_____**Phone #:**_____
(Please print)

I hereby authorize the below party to communicate and exchange with Windmoor through disclosure and/or receipt of my confidential information.

_____
Name of Person or Entity

_____
Address

_____
City

_____
Phone # Fax #

Authorizes any past, present or future records to be disclosed unless otherwise specified.
Date range of records specified if applicable: _____

I acknowledge, and hereby consent to such that the released information may contain Substance Use Disorder and Psychiatric Information: _____ **(Initial) Communicable disease including HIV/AIDS information.** _____ **(Initial)**

Information that may be released:

☐ **Any and All Medical/Psychiatric Records**	☐ **Letter of Treatment**	
☐ **Any and All Substance Use D/O Records**	☐ **Biopsycho Social Evaluation**	☐ **Treatment Plan**
☐ **Medication Record**	☐ **Physician's Psychiatric Evaluation**	☐ **Physician's Progress Notes**
☐ **History and Physical Exam Report**	☐ **Lab Results**	☐ **Nursing Notes**
☐ **Discharge Plan/Continuing Care Plan**	☐ **Discharge Summary**	☐ **Clinical Progress Notes**

☐ **Other (specify):**_____

PURPOSE FOR WHICH INFORMATION IS TO BE USED:

☐ Continuing Care	☐ School	☐ Disability benefits
☐ Legal	☐ Personal	☐ Employment conditions

☐ Other (Must be specific):_____

Information may be disclosed by the following methods: US mail, verbal, faxing, and encrypted email unless otherwise specified.
Other Specified Method: _____

AUTHORIZATION:
I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Revocation must be in writing. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure. Refer to the Notice for Privacy Practices regarding authorized disclosures. A legible copy of the Authorization or my signature thereon may be used with the same effectiveness as an original.

OTHER CONDITIONS:
This information has been disclosed to you from records whose confidentiality may be protected by Federal Law:
"I understand that my records are protected under Federal and State regulations governing the confidentiality and privacy of medical records and protected alcohol and drug abuse health information under 42 C.F.R Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R., Parts 160 and 164 and cannot be disclosed without my written authorization unless otherwise provided or by the regulations. I understand that I have a right to request a copy of this form. I understand that I might be denied services if I refuse to consent to a disclosure for treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to disclosure for other purposes. I also hereby release Windmoor from liability which may arise as a result of information disclosed under an authorization, if such information is disclosed is later used to my detriment.
This Authorization expires **1 year** from the date of signature unless otherwise specified:_____

_____
Signature of Patient **Date** **Signature of Parent/Guardian, if applicable** **Date**

_____
Witness, if applicable **Date**

Revocation: I hereby revoke the above authorization: Signature_____***Date***_____