WINDMOOR HEALTHCARE

11300 U.S. 19 North Clearwater, FL 33764

(727) 541-2646 FAX: (727) 322-7205

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

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

I authorize:	**To Release to:**
_____ Name of Person or Entity	_____ Name of Person or Entity
_____ Address	_____ Address
_____ City	_____ City
Phone # Fax #	Phone # Fax #

I acknowledge, and hereby consent to such that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

Dates of Service: _____

Information that may be released:

☐ **Medication Record**	☐ **Physician's Psychiatric Evaluation**	☐ **Physician's Progress Notes**
☐ **History and Physical Exam Report**	☐ **Lab Results**	☐ **Nursing Progress Notes**
☐ **Discharge Plan/Continuing Care Plan**	☐ **Discharge Summary**	☐ **Psychotherapy Progress Notes**

Other assessments: ☐ **Nursing** ☐ **Psychosocial** ☐ **Intake** ☐ **Other (specify):**_____

PURPOSE FOR WHICH INFORMATION IS TO BE USED:

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

If for legal purposes, give specific reason: (must be completed)_____

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:
"Federal regulation (42 CFR, Part 2) prohibits 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 as otherwise permitted by such regulations. 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." [RM 203, 7.2] Rev. 4-12-04

This Authorization expires **180** days from the date below unless otherwise specified: (cannot exceed **180 days):**_____

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

Witness, if applicable	**Date**

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