AUTHORIZATION - RELEASE OF INFO

I hereby authorize Ocala Consulting & Prevention, LLC 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
☐ Behavioral Observation
☐ Therapy/Counseling Notes
☐ Medical/Psychiatric Assessment & Treatment (Including Labs and Medications)
☐ Substance Use/Abuse Assessment & Treatment (Including Labs and Medications)
☐ 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: _____
Date of Birth: _____ Social Security Number: _____
Phone Number: _____ E Mail: _____

TO/FROM: Please enter name/address/phone/fax below:
Name: _____
Address: _____
Phone: _____ Fax: _____

For the purpose of (check one):
☐ To assist in the evaluation and treatment of the client
☐ Other (specify): _____

AUTHORIZATION - RELEASE OF INFO

A signed revocation may be submitted at any time, but Ocala Consulting & Prevention, LLC shall not be held liable for any information released prior to its receipt. Information disclosed under this authorization might be re disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law. Your signature on this authorization is not required to receive treatment. This release form shall be valid for (check one):

☐ A single disclosure (OR)

☐ A continuing disclosure for 90 days from signature date below (OR)

☐ A continuing disclosure for 1 year from signature date below.

To Receiving Agency:
PROHIBITION OF RE-DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further disclosure is strictly prohibited unless the client provides specific written consent for the subsequent disclosure of this information. A general authorization for the release of medical or other information is not sufficient to waive confidentiality of these records.

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.

☐ Client ☐ Parent/ Guardian

Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

Witness: _____ Date: _____

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