APALACHEE CENTER, INC.

AUTHORIZATION TO OBTAIN / DISCLOSE INFORMATION

Client Name: _____ Program: _____ Client #: _____
(Last, First MI)

AKA: _____ ■■■ - ■■ - ☐☐☐☐ DOB: ____/____/____

This will authorize the offices of Apalachee Center, Inc. to obtain and / or disclose the following medical and mental health treatment information. The release of available third-party information (i.e., records received from other providers) 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 in the restrictions below.

INFORMATION TO BE OBTAINED / DISCLOSED: *NOTE: Only the most recent edition / form will be disclosed unless a time frame is specified: ___/___/___ - ___/___/___.*

☐ INTAKE / PRELIMINARY ASSESSMENT	☐ NURSING ASSESSMENT	☐ CURRENT MEDICATION LIST
☐ PSYCHOSOCIAL HISTORY	☐ MEDICAL QUESTIONNAIRE	**PROGRESS NOTES (TIME FRAME REQUIRED)** ___/___/___ - ___/___/___
☐ PSYCHOLOGICAL EVALUATION / SUMMARY	☐ LAB / EKG REPORTS	
☐ PSYCHIATRIC EVALUATION	☐ TREATMENT PLAN	☐ Inpatient Psychiatric / Medical / Social Services
☐ HISTORY AND PHYSICAL EXAMS	☐ DISCHARGE INSTRUCTIONS	☐ Outpatient Psychiatric / Medical

☐ Other (must describe): _____

In addition to the information above, **I authorize the disclosure of information related to**: ☐ AIDS / HIV ☐ Drug / Alcohol Use

Name of Outside Party / Agency: _____
Program / Representative's Name: _____ **Relation to Client:** _____
Mailing Address: _____
Phone Number: (____) ____-____ **Fax Number**: (____) ____-____ **Email Address:** _____

For the purpose of: ☐ Coordination of Treatment / Continuity of Care ☐ Legal Issues ☐ Personal ☐ Discharge Planning
☐ Other: _____

This authorization expires in one year or another date not to exceed 12 months from the date of signature: ___/___/___.

The specified information may be exchanged between the above designated, authorized agencies or representatives unless otherwise restricted. I understand that information may be released verbally/orally, via copies, electronically, or by fax unless otherwise specified below. This authorization may be revoked at any time upon written notification by the client or authorized representative, but revocation has no effect on action previously taken. I understand that Apalachee may only condition treatment on obtaining 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 not longer be protected by Federal privacy regulations upon release by Apalachee Center, Inc.

Restrictions on Use / Disclosure of Information: ☐ N/A ☐ Restrictions: _____

_____ _____
Signature of Client *Date* **Signature of Guardian / Representative* *Date*

In most circumstances, when disclosing records relating to a minor ages 13 through 17, the signatures of both the minor and legal guardian/representative are necessary.

PROHIBITION OF RE-DISCLOSURE 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 information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identified by another person unless further disclosure is expressly permitted by 42 CFR part 2. A general authorization for the release of medical or other information is *NOT* sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

Revocation of Authorization: Date of Revocation: _____/_____/_____ **Time of Revocation:** _____ ☐ AM ☐ PM

Client Signature: _____ Staff / Witness Signature: _____