PALM POINT
Behavioral Health

2355 Truman Scarborough Way Titusville, FL 32780 Phone (321)603-6550

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Birth Date: _____

Maiden/Prior Name: _____ Current Phone #:_____

Current Address: _____

I am requesting disclosure of my protected health information for the following purpose:

☐ Continuing Care ☐ Disability Determination ☐ Child Custody ☐ Academic ☐ Legal Investagation

☐ Other: _____

Dates of Service Requested: _____

I authorize the release of the following:

☐ Continuity of Care Packet (Discharge Plan Part 1&2 My safety crisis plan, Medication Reconciliation, Advance Directive)

☐ Discharge Summary ☐ Psychiatric Evaluation ☐ History & Physical ☐ Lab/Diagnostic Reports

☐ Aclohol & Drug Abuse Treatment Program ☐ Physician's Orders ☐ Progress Notes

☐ HIV Test Results and AIDS Treatment Records ☐ Other: _____

To be released by: ☐ **Palm Point Behavioral Health**

☐ _____ _____ _____

Agency/Name Telephone Number Address

To be released to: _____ _____

Agency/Name Address

_____ _____

Telephone Number Fax Number

This authorization will expire on _____/_____/20____(If not indicated,authorization will expire one year from signature date) You have the right to revoke this authorization, by written request, at anytime. Exceptions to this can reviewd in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with copying of my informarion in the processing of this request. This form must be completed in full before signing.

_____ _____

Revocation Signature Date/Time

_____ _____ _____

Patient's Signature Parent/Legal Guardian Signature/Relationship Date

(required for ages 12 and older)

_____ _____

Witness Signature/Credentials Date Signed

This authorization is intended to allow Palm Point Behavioral Health to release information, both written and verbal, for the specfic purpose and life of the release and in the best interest of the patient. The release of information demonstrates compliance with the Health Insurance Portability and Accountablilty Act (HIPAA), Standards for Privacy of Individually Indentifiable Health Information (Privacy Standards), 45 CFR 160 AND 164, and all federal regulations and interpretive guidelines promulgated there under. Any infromation protected by Fedral Regulation governing confidentiality of alcohol and drug abuse patient records(42 CFR Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.