2840 SW 3rd Avenue
Miami, Florida33129
Phone (305) 857-0050 Fax (305) 854-4948

Authorization for Release of Information

I hereby request and authorize:

____
Name of Person(s) or Agency Holding the Information

____
Address Phone Fax

To release the written or verbal information specified below:

____

For the purpose of:

____

To: ____
Name of Person(s) or Agency Requesting the Information

____
Address Phone Fax

I understand that this form may be used to release information related to mental health treatment, including assessments and lab reports. Any release of substance abuse information must be pursuant to 42 CFR. There are other special restrictions which apply to the release of information regarding HIV, abuse reports, etc.I understand that I have the right to refuse to sign the authorization or to rescind my consent at any time prior to the release of Information.

____ __________
Signature of Client or Parent Printed Name of Client or Parent Date

____ __________
Signature of Witness Printed Name of Witness Date

Expiration Date: ________________

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further redisclosure is strictly prohibited unless the person provides a specific written consent for the subsequent disclosure of this information. Florida law requires that any person, agency or entity receiving information shall maintain such information as confidential and exempt from the provision of the public records law

Any release of information must be in compliance with the federal HIPAA law and state laws governing such releases.