FAMILY COUNSELING CENTER -- ST PETERSBURG

Diane HM Mandell MSSA, LISW, LCSW and Associates

Serving the Community Since 1993

RELEASE OF INFORMATION

This request is to Family Counseling Center to RELEASE OR RECEIVE protected information which includes behavioral health, mental health and/or substance use disorder information, 42 CFR Part 2 applies and **AN INFORMED CONSENT IS REQUIRED**: (individual must initial each item of information to be released). This form authorizes the release of Protected Health Information (PHI) pursuant to HIPAA 45 CFR Parts 160 and 164 and 42 CFR Part 2.

_____

CLIENT NAME CLIENT SSN DATE OF BIRTH

_____I authorize (THERAPIST NAME) _____ OR ___ FAMILY COUNSELING CENTER LLC to release information to the following agencies and/or specific individuals: _____

_____I authorize the following agencies and/or individuals to release information **to Family Counseling Center LLC or specific therapist (name): _____**

(Initial **ONLY ONE** above– *A separate ROI is required for releasing or receiving protected information)*

_____

Agency *Department or Name or Person* *Address*

Purpose for Release: _____

(Nature and amount of information to be disclosed should be as limited and specific as possible)

INFORMATION TO BE RELEASED:(please initial all that apply) ____**Behavioral/Mental Health** ____**Substance Use**

_____**Progress Notes**	_____ **General Summary Letter Only**	_____**Consultation Reports**
_____**Treatment Plans**	_____**Diagnosis (therapist)**	_____**Discharge Summary**
_____**History**	_____**Discharge Summary**	_____**Psychological Assessment**
_____**Drug & Alcohol Abuse Info.**	_____**Other**	

(Specify):_____

List types of health information you DO NOT WANT TO SHARE: _____

Dates of service to include: from _____ to _____

Authorization expiration date: _____

My consent will expire on the date noted above, or case, event, or condition closure unless I withdraw my consent. If the expiration date is blank or longer than one year, the consent will expire 1 year from the signature date.

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Notice to Recipient

This information has been disclosed to you from records protected by federal confidentiality rules 42 CFR Part 2 and 45 CFR Part 164 and Nevada Revised Statutes. The federal rules prohibit 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 42 CFR Part 2 or 45 CFR Part 164 or State of Florida Statutes. 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 patients.

Notice to Client: By signing this form, I understand:

- I am giving consent to share my behavioral health, mental health and/or substance use disorder information. Behavioral health, mental health and substance use disorder information includes, but is not limited to, referrals and services for alcohol and substance use disorders.
- My information will be shared to help diagnose, treat, manage and pay for my health needs.
- My consent is voluntary and will not affect my ability to obtain behavioral health, mental health, substance use or medical treatment, payment for such treatment, health insurance or benefits.
- My health information may be shared electronically.
- Other types of my information may be shared with my behavioral health, mental health and/or substance use disorder information. HIPAA allows my providers and other agencies to use and share most of my health information without my consent in order to provide me with treatment, receive payment for my care, and to manage and coordinate my care.
- The sharing of my health information will follow state and federal laws and regulations.
- This form does not give my consent to share psychotherapy notes as defined by federal law.
- I am responsible to notify all agencies and people listed on this form when I withdraw my consent.
- I can have a copy of this form.

Information for Informed Consent

Under the Health Insurance Portability and Accountability Act (HIPAA), a health care provider or agency can use and share most of your health information in order to provide you with treatment, receive payment for your care, and manage and coordinate your care. The confidentiality of behavioral health, mental health and substance use disorder information is protected by state and federal statutes, rules and regulations including State of Florida Statutes and Title 42 of the Code of Federal Regulations. These statutes, rules and regulations require that the individual give informed consent prior to the release of any health/hospital records or information, except as specifically provided for within the statutes, rules and regulations.

I understand that my alcohol and/or drug treatment records are protected under the state and federal statutes, rules and regulations including State of Florida Statutes, regulations governing confidentiality and drug abuse patient records 42 CFR Part

2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that my I may be denied services if I refuse to consent to a disclosure for purposes of treatment, payment or healthcare operations, as permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

A consent to release information will be considered valid only when it states: (1) who will release the information; (2) who will receive the information; (3) the purpose for which the information will be used; (4) what specific information will be released; and (5) when the consent will expire. The consent must contain the individual's or authorized representative's signature and the date of the signature. The authorized representative signing for the client must submit a copy of the legal document(s) granting this authority. A disclosure may not be made on the basis of a consent which: 1) has expired; 2) on its face substantially fails to confirm to any of the requirements set forth in this Authorization to Release Information; 3) is known to have been revoked or 4) is known, or through a reasonable effort could be known, by the person holding the records to be materially false.

EXCEPTIONS: There are certain limited circumstances under which behavioral health, mental health or substance use disorder disclosures can be made without patient consent. The circumstances include but are not limited to: 1) Medical Emergencies. Part 2 allows patient identifying information to be disclosed to medical personnel who have a need for the information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which required immediate medical intervention. 2) Subpoena and court—ordered disclosures. Unlike the HIPAA Privacy Rule information or other confidential information. Upon request, the individual will be given a copy of this completed "Authorization: Release of Information." T

This authorization is effective immediately and is subject to revocation in writing at any time, except to the extent that action has already been taken in reliance thereon. **Otherwise, this authorization expires _____ days** from the date of signing, but no longer than one year, or upon case, event or condition closure, whichever comes first. If I revoke this authorization, I am responsible for notifying all agencies and people listed in this form.

I understand that I must voluntarily and knowingly sign this authorization before any behavioral health, mental health or substance use disorder information can be released, and that I may refuse to sign, but in that event information cannot and will not be released.

I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered.

_____

SIGNATURE OF PERSON GIVING CONSENT OF LEGAL REPRESENTATIVE / DATE

_____

PRINT NAME OF PERSON GIVING CONSENT RELATIONSHIP TO INDIVIDUAL: ___Self ___Parent ___Guardian ___Authorized Representative ___Individual provided copy ___Individual declined copy

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REVOKE AUTHORIZATION TO RELEASE INFORMATION

I hereby revoke this authorization to release information.

_____

SIGNATURE OF PERSON GIVING CONSENT OF LEGAL REPRESENTATIVE DATE

_____

PRINT NAME OF PERSON GIVING CONSENT / RELATIONSHIP TO INDIVIDUAL: ___Self ___Parent ___Guardian ___Authorized Representative ___Individual provided copy ___Individual declined copy