



# PROVIDERS FOR HEALTHY LIVING

Child, Adolescent, and Adult Psychiatry & Therapy Services

PHONE AND FAX - 407-219-3281

## Authorization for Release of Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

I authorize Providers for Healthy Living to exchange information with:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

PURPOSE OF THIS REQUEST:  Healthcare  Insurance Coverage  Personal  Other

TYPE OF RECORDS AUTHORIZED:  Psychiatric/Psychological Evaluation and/or Treatment

Drug/Alcohol Evaluation and/or Treatment

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

ALL INFORMATION CAN/SHOULD BE EXCHANGED AS NECESSARY

- Assessments
- Progress Notes
- Laboratory Test Results
- Diagnostic Impression
- Discharge Summary
- Treatment Plans
- Treatment Summary
- Other: (please describe) \_\_\_\_\_

**Periodic Use/Disclosure:** I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document. My authorization will expire when I am no longer receiving services from Providers for Healthy Living.

***I understand that:***

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a *written* request to Providers for Healthy Living.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional information.
- If the medical record information is not sent to another care provider, there may be a charge of the requested records.

PLEASE CHECK ONE OR MORE OPTIONS: \_\_\_\_\_ SEND MY RECORDS TO THE PROVIDER/FACILITY ABOVE ASAP  
\_\_\_\_\_ REQUEST MY RECORDS FROM THE PROVIDER/FACILITY ABOVE ASAP  
\_\_\_\_\_ KEEP THIS RELEASE ON FILE FOR USE AT A LATER TIME  
\_\_\_\_\_ RELEASE PHL RECORDS AND RECORDS OBTAINED FROM OTHER PROVIDERS, MEDICAL FACILITIES, OR OTHER EXTERNAL ENTITIES

Signature of Patient or Representative: \_\_\_\_\_

Printed Name of Person Signing Form: \_\_\_\_\_

Relationship to Patient (if requester is not the patient):  Parent  Legal Guardian  Other: \_\_\_\_\_

Date: \_\_\_\_\_