VINCENT HOUSE
AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

Client Name:______________________________________ A.K.A.____________________________________

Social Security #:___________________________________ D.O.B.____________________________________

THIS WILL AUTHORIZE ____
to release general medical as well as psychiatric/psychological information from my medical record in accordance with Florida Statutes (394.459 (9), 381.609 (2) (F), 395.3025, 90.503, 458.21, 396.112, 397.053, 490.32, 90.42 and Federal Law CFR II).

The release of any information concerning HIV, AIDS, ARC, AIDS-Related Complex (ARC) and the performance of any tests, counseling and results and treatment thereof are also authorized. I understand that my records have a privileged and confidential status. I am waiving that status for the purpose contained within this authorization.

THE SPECIFIC INFORMATION REQUESTED IS:
Please **Initial** each item requested; a check mark in any category will not authorize release:

______Psychiatric Evaluation (must be initialed)

______Drug/Alcohol Treatment (must be initialed)

______Vincent House Referral Form (must be initialed)

______Other (must specify) ____

THIS INFORMATION IS TO BE RELEASED IN THE MANNER INITIALED:

______ Written ______ Verbal ______ Fax

Release Information To: **Vincent House**
4801 78th Avenue North
Pinellas Park, FL 33781
(727) 541-0321
Fax (727) 541-0355

FOR THE PURPOSE OF CONTINUITY OF CARE

A general medical authorization and subpoena duces tecum without a specific authorization to release psychiatric information MUST have this waiver from the patient or his empowered representative.

I UNDERSTAND that I have the right to refuse to sign this authorization. I understand that I am not required to sign this authorization in order to receive services, with limited exceptions.

I UNDERSTAND that I am authorizing the release of information from records whose confidentiality and privileged status is protected by Federal Regulations and Florida Statutes, and any re-disclosure of this information by the receiving agency is PROHIBITED.

THIS AUTHORIZATION IS FOR single or continuing disclosure, valid until ______________________. (Not valid for more than 365 days). This authorization may be revoked at any time upon written notification by the signatory or patient but revocation has no effect on action previously taken.

Signature of Patient:____ Date:_______________

Signature of EMPOWERED REPRESENTATIVE:______________________________ Date:_______________
(Legal papers must accompany release) (If patient is a minor and unable to sign)

Signature of WITNESS:____ Date:_______________

The above information was released on:__________________, by________________________________

TO BE VALID THIS FORM MUST BE FILLED OUT COMPLETELY