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CONSENT AND AUTHORIZATION TO RELEASE/REQUENT CONFIDENTIAL INFORMATION INCLUDING MEDICAL, HIV, PSYCHOLOGICAL AND SUBSTANCE ABUSE RECORDS

Patient Name: _____ Birth Date: _____

I am the adult patient or the parent/legal guardian of the above child and have the legal right to consent to release/ request confidential medical psychological information on his/ her behalf. At my request, I knowingly and voluntarily permit Dr. Hagerott or her administrative staff to:

❑ **Release necessary information to my insurance company or third party payer:**_____ for the processing of my claim (Released information my include dates of services, diagnoses, treatment plan, psychotherapy notes, progress notes, letters documenting medical necessity for services, or prepared evaluation reports for the purposes of authorizing, billing and payment for services. If necessary, indicate information you do not want released here: _____)

❑ **Release Records or clinical Information**: I authorize Dr. Hagerott to release any clinical records including written or oral communication, psychotherapy notes, progress notes, prepared evaluation reports, to:

1._____ 3._____

2._____ 4._____

Any information you do NOT want released should be indicated here: _____

❑ **Records Request:** I authorize the following to release my records to Dr. Hagerott:

1._____ Information Requested: _____

2._____ Information Requested: _____

I understand that I may revoke this consent to release information at any time; however, I also understand that any communication that was made prior to my written revocation and relied on this authorization shall not constitute a breech or my right to confidentiality. Unless I revoke this authorization prior to such, this authorization to release/ request information will expire one year from the date of signing unless otherwise indicated here _____. At that time, no express revocation shall be needed to terminate my consent. I hearby release the persons/ facilities named above from any liability that may arise as a result of the use of the inforamtion contained in the records after they are relased and understand that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA privacy rule.

Signature _____ Relationship to patient _____ Date: _____

Signature of Witness _____ Date:_____

To receiving agency: The information contained in this form is in compliance with Florida Statues, Section 394.495(9), and Federal Law Title 42, CFR Chapter II, Part II. **Prohibition of redisclosure:** This information released is from records whose confidentiality is protected. Any further disclosure is strictly prohibited unless the patient provides specific written consent for the subsequent disclosure of this information.