

South County Mental Health Center, Inc. 16158 South Military Trail Delray Beach, Florida 33484 (561) 495-0522 / 737-8400 Fax (561) 496-5064	AUTHORIZATION TO DISCLOSE OR OBTAIN PROTECTED HEALTHCARE INFORMATION (PHI) Client Name: _____ Chart #: _____ D.O.B. _____ S.S. #: _____
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I hereby request and authorize To/From: _____

Name of person(s) or agency holding the Information: **SOUTH COUNTY MENTAL HEALTH CENTER, INC.**

Address: **16158 SOUTH MILITARY TRAIL DELRAY BEACH, FL. 33484**

Phone#: **(561) 495 – 0522/ 737 - 8400**

*To release written or verbal mental health and other information specified below:

☐ Admission Summary	☐ TCM Assessment	
☐ Discharge Summary	☐ Medication History	From: _____ (Date) To: _____ (Date)
☐ History & Physical	☐ Lab Reports	From: _____ (Date) To: _____ (Date)
☐ Psychiatric Evaluation	☐ Progress Notes	From: _____ (Date) To: _____ (Date)
☐ Biopsychosocial Evaluation	☐ School Records	
☐ Treatment Plan	☐ Aftercare Plan	☐ Client Status
☐ Narrative Summary	☐ () Verbal Progress Summary	
☐ Drug & Alcohol Treatment Records	☐ Intake Assessment	☐ Other: _____

To/From: _____ Phone#: _____

Name of person(s) or agency requesting information: _____

Address _____

For the purpose of: _____

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 part 2 and HIPAA regulation 45 CFR. There are other special restrictions that apply to the release of information regarding HIV, abuse reports, etc. I also understand that if my medical condition contains treatment notes, diagnosis, or test results of HIV/AIDS and/or related conditions, these records shall also be released. I understand that once the above information is disclosed, then it may not be protected by Federal or State Privacy Laws or Regulations.

I understand that I have the right to refuse to sign this authorization or to rescind my authorization at any time prior to the release of the information. Cancellation will be effective upon the date the notice is received by the provider, but shall exclude information already furnished to the recipient before the date. A general medical authorization and subpoena duces tecum without a specific authorization to release psychiatric information must have this waiver from the client or his/her empowered representative. **In the absence of my written notice, this authorization shall be revoked automatically 1 (one) year after the date of the consent as it appears below.**

FORM(S) IN WHICH INFORMATION IS TO BE RELEASED: ORAL _____ WRITTEN _____ FAX _____

Expiration Date: _____

Email: _____ Fax#: _____

Signature of Competent Client	Printed Name of Competent Client	Date (mm/dd/yy)	Time (am/pm)
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When applicable, Signature of: () Guardian, () Guardian Advocate, () Health Care surrogate/proxy or () Personal Representative (if deceased)	Printed Name of Substitute Decision Maker	Date (mm/dd/yy)	Time (am/pm)
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Signature of Witness	Printed Name of Witness	Date (mm/dd/yy)	Time (am/pm)
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I wish to revoke my authorization to release HIM information: Initials _____ Date _____

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected pursuant to 42 CFR part 2, HIPAA regulation 45 CFR, and Florida Statutes 394.4615, and Florida Administrative Code 65E5.250. Any further disclosure is strictly prohibited unless the client provides specific written authorization 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 provisions of the public record law. Date sent out: _____