AUTHORIZATION FOR RELEASE AND/OR REQUEST FOR INFORMATION *Clinical Services*

_____ SS#: _____-_____-_____ DOB: ____/____/____
Participant's Name **(Please Print)**

TO**:** _____ Date: _____
Name of Person(s), and/or Agency Organization to which information is to be released/requested

FROM: _____ Date:_____
Name of Person(s), and/or Agency Organization to which information is to be released/requested.

I, _____, Parent or legal guardian of _____ hereby authorize the person(s)/agency above and Atroypen Group, Inc. **to engage in verbal or written communication concerning me/or my child regarding the records and information listed below. I understand that information concerning psychiatric, psychological, medical diagnoses, and substance use will be released upon request. I also understand that if my medical information contains treatment notes, diagnoses, and/or test results related to HIV/AIDS and/or related conditions, these medical records shall require a specific and detailed authorization for release. I am aware that this information will be strictly confidential and will only be used in my/or my child's best interest in order to provide the most appropriate services. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in Florida or Federal Law.**

RECORDS TO BE RELEASED FROM PBG	**RECORDS BEING REQUESTED (OTHER AGENCY)**
_____ Treatment Plan	_____ Treatment Plans
_____ Progress Reports	_____ Progress Reports
_____ Medical Records	_____ Health/Medical Record
_____ Education Reports	_____ Education Reports
_____ Discharge Summaries	_____ Discharge Summaries
_____ Psychosocial/Psychiatric Eval.	_____ Psychosocial/Psychiatric Eval.
_____ Social/Development History	_____ Social/Development History
_____ Verbal Communication	_____ Verbal Communication
_____ Other (Specify) _____	_____ Other (Specify)_____

For the purpose of: _____

Restrictions (if any): _____

_____ (initial) I understand that the information will **NOT** be disclosed to any other party without prior written consent of the legal guardian (if a minor).
_____ (initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the case records department.
_____ (initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and AGI will not base my treatment, payment or eligibility for benefits on whether or not I provide authorization for the requested use or disclosure. I understand that the recipient may be prohibited from disclosing substance abuse information. I understand that I may inspect or obtain a copy of the information to be released, as provided in CFR164.524 (with reasonable charge).
_____ (initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and the information is no longer protected by federal confidential laws or Atroypen Group, Inc.
_____ (initial) I understand that Atroypen Group, Inc. will release only the minimum amount of information necessary to fulfill a request.

This release is protected under State and Federal Confidentiality Regulations Title 42 (CFR) Part 2, and FS 90.503) and all requirements and applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA).
I understand that this authorization will remain in effect for a period of 90 days (commencing on the date this form is signed) and that I may revoke this consent at any time. Revocation does not pertain to prior disclosures.

Expiration Date:_____ **(A copy is valid in lieu of the original).**

Release:

_____ ____/____/_____
Participant/Parent Guardian Signature Date

_____ ____/____/_____
Witness Date

Request:

_____ ___/___/___/_____
Participant/Parent/Guardian Signature Date

_____ ___/___/____
Witness Date

Revocation: I hereby revoke my permission to disclose information effective _____, 20_____. I understand that this does not effect information released prior to this date.

_____/_____/_____ _____
Date **Signature of Parent or Guardian**