APALACHEE CENTER, INC.
RELEASE OF INFORMATION

Client Name: _____ *Program:* _____ *Client#:* _____
Last *First* *M*

AKA: _____ *SSN:* ■■■-■■- _____ *DOB:* _____

This will authorize the offices of Apalachee Center, Inc. to disclose and / or obtain the following medical, mental health, alcohol, and / or drug abuse treatment information. The release of available third-party information {i.e., records received from other providers) or information concerning AIDS/HIV tests, counseling, and the results and treatment thereof is authorized unless otherwise specified. The releasing agent is authorized to act on behalf of a copy/ facsimile of the original form unless otherwise specified in the restrictions below.

INFORMATION REQUESTED: ☐ Most Recent Assessment / Form ☐ Date Range: _____ - _____

☐ INTAKE/ PRELIMINARY ASSESSMENT	☐ NURSING ASSESSMENT	☐ MEDICATIONS LIST
☐ PSYCHOSOCIAL HISTORY	☐ MEDICAL QUESTIONNAIRE	**PROGRESS NOTES *(Time Frame Required/***
☐ PSYCHOLOGICAL EVALUATION/ SUMMARY	☐ LAB / EKG REPORTS	_____ - _____
☐ PSYCHIATRIC EVALUATION	☐ TREATMENT PLAN	☐ Inpatient Psychiatric / Medical / SS
☐ HISTORY & PHYSICAL EXAM SUMMARIES	☐ DISCHARGE INSTRUCTIONS	☐ Outpatient Psychiatric / Medical

☐ Other (must Describe): _____

Name of Outside Party Name / Agency: _____

Program / Representative's Name: _____ **Relationship to Client:** _____

Mailing Address/Phone: _____

For the purpose of: ☐ Coordination of Treatment/Continuity of Care ☐ Legal Issues ☐ Personal ☐ Discharge Planning

☐ Other: _____

Specific information to be EXCLUDED from this Authorization: ☐ N/A ☐ Drug/Alcohol ☐ HIV/AIDS ☐ Other: _____

This authorization expires: ☐ 12 months from signature ☐ _____ (not to exceed 12 months from Signature)

The specified information may be exchanged between the above designated, authorized agencies or representatives unless otherwise restricted. I understand that information may be released verbally/orally, via copies, electronically, or by fax unless otherwise restricted below. This authorization may be revoked at any time upon verbal or written notification by the client or authorized representative, but revocation has no effect on action previously taken. I understand Apalachee may only condition treatment on obtaining signed authorization when providing services solely for the purpose of creating information for disclosure to a third-party and this authorization is for disclosure to that third-party, I understand that information disclosed to non-healthcare providers (or entities not governed by applicable law) may no longer be protected by Federal privacy regulations upon release by Apalachee Center, Inc.

Restrictions on Use/ Release of Information: ☐ N/A _____

If responding to a request for records, please send the records to the following

Apalachee Center Address: _____

_____ _____ _____ _____
Signature of Client* ***Date*** ***Signature of Guardian/Representative**** ***Date***

_____ _____
Witness Signature ***Date***

For releasing records relating to a minor between the ages of 12-18, the signatures of both the minor and legal guardian/representative are necessary,

PROHIBITION ON REDISCLOSURE OF INFORMATION PERTAINING TO ALCOHOL AND DRUG ABUSE RECORDS:

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identified by another person unless further disclosure is expressly permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

Cancellation/ Revocation of Authorization: Date of Revocation: _____

Nature of Request: _____ ***Staff/Witness Signature:*** _____