



Authorization to Release or Obtain Confidential Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Admission: \_\_\_\_\_

I authorize Coral Shores Behavioral Health, 5995 SE Community Drive, Stuart FL 34997 | Phone: 772.403.4000 |

Fax: 772.403.4129 to Release or Obtain information by mail, courier, email, or fax transmittal to/from:

Person or Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

The following information is to be disclosed:

- Discharge Care Plan  Discharge Summary  Lab Test / X-Rays  Psychosocial Assessment
 Intake Assessment  Baker Act (IVE)  Psychiatric Evaluation  Facesheet
 History & Physical Examination  Medications  Treatment Plan  Verbal discussion of treatment
 All records  Other: \_\_\_\_\_

For the purpose of: Continuing Care Personal Other: \_\_\_\_\_

NOTICE TO PATIENT AND RECIPIENT OF RECORDS

I understand that this form may be used to release information related to psychiatric (mental health) treatment, drug/alcohol use, and/or HIV/AIDS. I understand I have the right to refuse to sign this authorization and/or to rescind my consent at any time. Treatment or payment for services are not conditioned on signing this authorization. If I do not revoke this authorization, it will automatically expire 90 days from the date of signature unless otherwise noted. The consent expires on \_\_\_\_\_ if not revoked earlier.

\_\_\_\_\_  
Patient's Signature Printed Patient's Name Date / Time am pm

\_\_\_\_\_  
When applicable, signature of: Printed Name Date / Time am pm
Parent Guardian Guardian Advocate HealthCare Surrogate / Proxy Power of Attorney
Personal Representative / Equivalent (if deceased)

\_\_\_\_\_  
Signature of Witness Printed Name of Witness Date / Time am pm

This information has been disclosed from records protected by Federal confidentiality rules, Florida Statutes 394-459, 397.501, and/ or 90.503 and 42 Code of Federal Regulations (42 CFR). This release demonstrates compliance with HIPAA Standards for Privacy of Individually Identifiable Health Information 45 CFR, 160 & 164, and all federal regulations and interpretative guidelines promulgated there under. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and Florida Statutes 349-459, 397.501, and/or 90.503. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand that this authorization is subject to revocation by me at any time. Once the requested protected health information is disclosed, the Privacy Regulation may no longer protect it if the PHI's recipient re-discloses it. Further, I understand that despite all care taken, information is occasionally received by a party not intended to be the recipient. I hereby release CSBH from all liability should this information be received by someone other than the above-intended recipient.