COMMUNITY PARTNERS OF SOUTH FLORIDA
HEALTH | HOUSING | COMMUNITY
2001 W. Blue Heron Blvd., Riviera Beach, FL 33404
Phone (561) 841-3500 Fax (561) 844-3577

Authorization To Obtain and Release Information

Client Name: _____ Date of Birth _____ MR# _____

This will authorize **Community Partners of South Florida** to disclose to and/or obtain from: _____

_____
Name of Person or Organization, and address

for the **purpose** of improving assessment and treatment planning, and sharing information relevant to coordinate care.
This authorizes verbal communication between parties above, and authorizes entrance into the facility for purpose of providing services.

Description of Information to be Disclosed (please strike through and initial any information you do not want Disclosed):
Assessments, Treatment Plan, Progress Summary, Progress Note(s), Discharge/Transfer Summary, Other (specify)_____

Description of Information to be Obtained (please strike through and initial any information you do not want to be Obtained):
Nursing/Medical Information, Medication Log, Treatment Plan, Education Information (IEP, Psycho-Educational, Progress Reports, etc.), School Disciplinary Reports, Toxicological Reports/Drug Screen, Progress Summary/Notes, Assessments, Psychiatric Evaluation, Psychological Evaluation, Discharge/Transfer Summary, Other (specify)_____

I understand that my behavioral health treatment records are protected under the federal regulations covering confidentiality of Drug and Alcohol Abuse Patient Records, 42 Code of Regulations (CFR) Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Parts 160 and 164, FL Chapters 394, and 397, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand that I may **revoke** this consent in writing, except to the extent that action has already been take on reliance of it, and that in any event this authorization automatically **expires** after one year, unless otherwise stated here: _____
I understand that Community Partners of South Florida will not **condition** my treatment on whether I give authorization for the requested disclosure. The consequences of refusing to sign this authorization have been explained to me.

Form of Disclosure: I understand I may request in writing that disclosure be made in a certain format. otherwise the agency reserves the right to disclose information as permitted by this authorization in any manner deemed to be appropriate and consistent with applicable law, including but not limited to verbally, written, facsimile or electronically.

Housing Partnership, Inc., under a Management Agreement d/b/a Community Partners of South Florida, may disclose any and all client information as outlined in the mutually executed Business Associate Addendum as authorized by law related to disclosures for treatment, payment, health care operations, and performing certain insurance functions.

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, Florida Administrative Code 65E5.250, and FL Chapter 397. 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. We will not re-disclose any protected health information received from other parties, that may be present in your record.

_____	_____	_____
Client Printed Name	Client Signature	Date
_____	_____	_____
Parent/Guardian Printed Name	Parent/Guardian Signature	Date
_____	_____	_____
Witness Printed Name	Witness Signature	Date