AUTHORIZATION TO DISCLOSE PATIENT INFORMATION

I, _____ _____ _____
Name of Patient *(Please print)* Date of Birth/last four # SSN Phone Number

Hereby authorize: **Wekiva Springs,**
3947 Salisbury Road,
Jacksonville, Florida 32216
(904)-296-3533, Fax# (904) 899-8752 (Medical Records)

(check box or boxes)To obtain from ❑ and/or disclose to ❑ protected health information as indicated below to:

Name: _____ **Agency:** _____

Facility: _____

Please indicate if these records are to be released via fax or mail
FAX # If records are to be faxed: _____
Must have a mailing address even if records are not being mailed
Mailing Address:

You must make a selection:

PROTECTED MENTAL HEALTH / SUBSTANCE ABUSE INFORMATION TO BE OBTAINED AND / OR DISCLOSED (*must be specific*):

❑ Discharge Summary ❑ Psychiatric Evaluation ❑ History & Physical ❑ Lab Reports ❑ Physician's Orders

❑ Drug Abuse & Psychiatric Assessments ❑ Treatment Plan(s) ❑ Other (*specify*):_____

❑ Verbal Information (***specify***):_____

_____

PURPOSE INFORMATION IS BEING USED / DISCLOSED (*must be specific*):

❑ Continuing Care ❑ Legal Issues ❑ Insurance ❑ Disability Claim ❑ Other (*specify*): _____

- **I authorize the use and disclosure of protected health information**, including but not limited to, **medical, psychiatric, psychological, drug/alcohol**, and **HIV/AIDS** records as indicated above. I release **Wekiva Springs**, its employees, agents, directors, officers, and affiliates, from any liability that may be incurred by giving this information to the above-named person or agency.
- **I understand that I have the right to revoke this authorization at any time**. To revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been used/disclosed in response to this authorization or information disclosed for the purpose of receiving reimbursement from a third-party payer.
- I understand that this authorization will **expire 90 days** from the signature below.
- I understand that **Wekiva Springs** will not determine treatment or payment based on my approval or denial of authorization.
- I understand that this information being disclosed is confidential and protected by federal law. The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations, including the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**). Federal regulations (**42 CFR, Part 2**) prohibit the receiver of this information from making any further disclosures of the same, except with the written authorization of the person to whom it pertains. A General Authorization for the release of medical/psychiatric information is not sufficient for this purpose.
- I further understand that once this information has been disclosed to the person/organization listed above, **Wekiva Springs** no longer may provide protection against further uses and/or disclosures by said person/organization or any subsequent recipient.
- I have read, or been informed, that all blanks were properly filled in prior to my signature. I understand that, by signing this form, I am confirming my authorization that **Wekiva Springs** may receive, use, and/or disclose to the persons and/or organizations named in this form.
- **To disclose confidential discussions between you and the therapist, Please Initial here:** ❑N/A_____

_____ _____ _____
Signature of Patient *(includes minors 16 years and older)* Signature of Witness Date/Time

_____ _____ _____
Signature of Requestor (if other than Patient)* Signature of Witness Date/Time
Relationship to patient __ Parent ___ Legal Guardian (i.e., Power of Attorney, custodial parent, etc) ___ other

Processed by: _____ _____
Name Date/Time