Authorization for Release of Information

I hereby request and authorize:

_____
Name of Person(s) or Agency Holding the Information

_____
Address

to release written or verbal information specified below:

_____

_____

To:_____
Name of Person(s) or Agency Requesting the Information

_____
Address

For the purpose of: _____

I understand that this form may be used to release information related to mental health treatment, including assessments and lab reports. Any release of substance abuse information must be pursuant to 42 CFR 2.31(a). There are other special restrictions which apply to the release of information regarding HIV, abuse reports, etc.

I understand that I have the right to refuse to sign this Authorization or to rescind my consent at any time prior to the release of the information.

Expiration Date: _____ Social Security Number of Person: _____

_____	_____	_____	_____ am pm
Signature of Competent Adult	Printed Name of Competent Adult	Date	Time
_____	_____	_____	_____ am pm
When applicable, Signature of: ☐ Guardian, ☐ Guardian Advocate, ☐ Health Care Surrogate/Proxy, or ☐ Personal Representative/Equivalent (if deceased)	Printed Name of Substitute Decision Maker	Date	Time
_____	_____	_____	_____ am pm
Signature of Witness	Printed Name of Witness	Date	Time

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further redisclosure is strictly prohibited unless the person provides specific written consent 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 records law.

Any release of information must be in compliance with the federal HIPAA law and state laws governing such releases.

See s. 394.4615(2)(a), Florida Statutes
CF-MH 3044, Dec 2020 (obsoletes previous editions) (Recommended Form)
[65E-20.003, F.A.C.]

BAKER ACT