Advanced Psychiatry & Addictions Specialists

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Board Certified Psychiatrist

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CLIENT AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION AND WAIVER OF PRIVILEGE OF CONFIDENTIALITY

CLIENT NAME_____ DATE OF BIRTH _____

AUTHORIZATION (Please initial) _____ REQUEST INFORMATION _____ RELEASE INFORMATION

I authorize Dr's Allen request/release information relating to, and records of, the client named above. This release is pursuant to Federal Regulations (Title 42, US Code, sections 290dd-3 and 290ee-3 and CFR Part 2) and Florida Statutes (FS 90.503, 90.5035, chapters 381, 383, 384, 390, 391, 392, 393, 394, 395, 397, 415, 445, 490, 491).

If this authorization covers information pertaining to a minor child, the undersigned represents that he/she is the legal guardian and primary custodian of the minor, with full authority to execute this authorization and release.

I understand that this release not only covers the provision and receipt of all records maintained by Dr Allen, but also authorizes any member of the staff, employee of, or entity contracting with Dr's Allen to discuss the case, treatment, and records with the persons authorized to receive information either in private conversations, depositions, or court testimony.

I have read and fully understand the terms of this release and waiver.

Information covered by this authorization may be released to / requested from the following:

(1) Facility / Person _____
Phone/Fax_____
The information and records are for the purpose of _____
Information to be released includes (check one)
___all information including medical, psychiatric, psychological, HIV/AIDS, alcohol and drug or other substances
___specific information/reports, such as_____

(2) Facility / Person _____
Phone/Fax/Email_____
The information and records are for the purpose of_____
___all information including medical, psychiatric, psychological, HIV/AIDS, alcohol and drug or other substances
___specific information/reports, such as_____

I understand this authorization will remain in effect until it revoked by written notification to this office.

OR

This authorization expires on _____

CLIENT SIGNATURE _____DATE _____
(OR SIGNATURE OF EMPOWERED REPRESENTATIVE)

WITNESS SIGNATURE_____DATE _____