Serving Children and Reaching Families, LLC (SCARF)

1216 Patrick Street, Kissimmee, Florida 34741
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AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT HEALTHCARE INFORMATION

Patient Name (please print):_____
Address: _____
Date of Birth: _____ Telephone: _____ Alternate #_____

I authorize: ☐ Targeted Case Manager ☐ Licensed Assessor ☐ SCARF Privacy Officer
☐ Mental Health Counselor ☐ Psychiatrist ☐ Psychosocial Rehabilitation Specialist
☐ Other _____

☐ To give my health information to: ☐ To receive my health information from: OR ☐ To discuss my health information with:

Name: _____ Address:_____
_____ _____

Please specify applicable dates of service: _____

Please specify information to be released (below):
[ ] Office Notes/Treatment
[ ] History & Physical
[ ] Therapy Progress Notes
[ ] Discharge Summary
[ ] TCM Assessment/Care Plans/Notes
[ ] Psychosocial Evaluation
[ ] Substance Abuse Assessment
[ ] Psychiatric/Psychological Evaluation
[ ] Behavioral Health Admission Status
[ ] Individual Treatment/Service Plan
[ ] Other information to be released: _____

I release the above information for the purpose of (below):
[ ] Ongoing treatment/ Continuity of Care
[ ] Involving family members during my admission*
[ ] Release is to the requesting individual for their own record/use*
[ ] Legal proceeding/Insurance matter*
[ ] Other*: _____

State and Federal laws require your specific consent to disclose any of the following types of information
(check the boxes next to the disclosures you wish this authorization to include):

☐ **I authorize the disclosure of substance abuse program information contained in my medical records.**
Check this box if you wish this authorization to authorize the disclosure of information maintained by a substance abuse program, substance abuse medical practitioner, or substance abuse unit within a general medical facility from which you received diagnosis, treatment or referral for alcohol or drug abuse. If you authorize the disclosure of substance abuse program information, such information may not be re-disclosed by the recipient of the information unless you provide your written consent or such re-disclosure is otherwise permitted by 42 C.F.R. Part 2.

☐ **I authorize the disclosure of mental health facility information contained in my medical records.**
*Check this box if you wish this authorization to authorize the disclosure of mental health information maintained by a licensed mental health treatment facility, including a mental health clinic. Initial here if you wish to review your mental health facility information prior to its disclosure*_____

☐ **I authorize the disclosure of HIV (Human Immunodeficiency Virus) information contained in my medical records.**
Check this box if you wish this authorization to include the disclosure of HIV test results and medical records containing information related to HIV infection status or AIDS (Acquired Immune Deficiency Syndrome). If you check this box, you should understand that persons who have disclosed HIV information have encountered discrimination from others in the areas of employment, housing, education, life insurance, health insurance, and social and family relationships.

I Understand that:

- ✓ If I received substance abuse or mental health treatment or a referral for such treatment from a health care practitioner or facility other than a substance abuse program or a licensed mental health facility, information about the substance abuse or mental health treatment I received from such practitioner or facility may be disclosed pursuant to my authorization to disclose general health care information
- ✓ Signing this authorization is not a condition to treatment, payment, enrollment, and eligibility for benefits.
- ✓ I can refuse to disclose some or all of the information in my treatment records, but if I do so, it could result in an improper diagnosis or treatment, denial of coverage, or a claim for health benefits or other insurance or other adverse consequences.
- ✓ I can revoke all or part of this authorization, in writing, at any time by delivering a written, dated, and signed notification or I can make an oral statement revoking this authorization to the facility indicated above except to the extent that SCARF facility has already acted in reliance on it. Revocation may be the basis for the denial of health benefits or other insurance coverage or benefits
- ✓ I am entitled to a copy of this authorization, upon request.
- ✓ Information disclosed pursuant to this authorization may be re-disclosed by the recipient and therefore no longer protected by the privacy laws.
- ✓ I can cross out any provision on this form with which I disagree.
- ✓ Subsequent disclosures may not be made pursuant to the same authorization unless authorized by me.
- ✓ All records are maintained according to State Regulatory guidelines. Some older records may not be available for release that are beyond retention periods.
- ✓ Florida law allows reasonable fees to be collected for copies of medical records which may not exceed processing costs. SCARF does not charge for copies of records provided for continuing care.
- ✓ There is a cost of $.75 cents per page for other purposes of release of medical records - *fee may apply
- ✓ **A copy of this release shall be valid as the original.**

This authorization is effective until: _____ **(date not to exceed one (1) year).** The one year limit applies to records dated on or before the date indicated below. Records created after this date requires a new authorization form to be completed.

_____ _____

Signature of Patient/Legal Guardian Date

_____ _____

Signature of Authorized Representative Relationship

THIS RELEASE MUST BE FILLED OUT COMPLETELY - PLEASE READ CAREFULLY

Notice to Recipient: This information has been disclosed to you from records protected by Federal confidentiality regulations 42 CFR Part 2 and state law requirements. Under such law, the information received pursuant to this document is confidential and prohibits the recipient from making further re-disclosure of this information to any other person or entity, or to use it for a purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug patients.

FOR INTERNAL USE ONLY

Received/Released By: _____ Date: _____

Approved By: _____ Date: _____

Denied By: _____ Date: _____

Reason Denied: _____