

**VINCENT HOUSE
AUTHORIZATION TO RELEASE/OBTAIN INFORMATION**

Client Name: _____ A.K.A. _____

Social Security #: _____ D.O.B. _____

THIS WILL AUTHORIZE _____
to release general medical as well as psychiatric/psychological information from my medical record in accordance with Florida Statutes (394.459 (9), 381.609 (2) (F), 395.3025, 90.503, 458.21, 396.112, 397.053, 490.32, 90.42 and Federal Law CFR II).

The release of any information concerning HIV, AIDS, ARC, AIDS-Related Complex (ARC) and the performance of any tests, counseling and results and treatment thereof are also authorized. I understand that my records have a privileged and confidential status. I am waiving that status for the purpose contained within this authorization.

THE SPECIFIC INFORMATION REQUESTED IS:

Please **Initial** each item requested; a check mark in any category will not authorize release:

_____ Psychiatric Evaluation (must be initialed)

_____ Drug/Alcohol Treatment (must be initialed)

_____ Vincent House Referral Form (must be initialed)

_____ Other (MUST SPECIFY) _____

THIS INFORMATION IS TO BE RELEASED IN THE MANNER INITIALED:

_____ Written _____ Verbal _____ Fax

Release Information To: **Vincent House**
 4801 78th Avenue North
 Pinellas Park, FL 33781
 (727) 541-0321
 Fax (727) 541-0355

FOR THE PURPOSE OF CONTINUITY OF CARE

A general medical authorization and subpoena duces tecum without a specific authorization to release psychiatric information **MUST** have this waiver from the patient or his empowered representative.

I UNDERSTAND that I have the right to refuse to sign this authorization.

I UNDERSTAND that I am authorizing the release of information from records whose confidentiality and privileged status is protected by Federal Regulations and Florida Statutes, and any re-disclosure of this information by the receiving agency is PROHIBITED.

THIS AUTHORIZATION IS FOR single or continuing disclosure, valid until _____.
(Not valid for more than 180 days). This authorization may be revoked at any time upon written notification by the signatory or patient but revocation has no effect on action previously taken.

Signature of Patient: _____ Date: _____

Signature of EMPOWERED REPRESENTATIVE: _____ Date: _____
(Legal papers must accompany release) (If patient is a minor and unable to sign)

Signature of WITNESS: _____ Date: _____

The above information was released on: _____, by _____

TO BE VALID THIS FORM MUST BE FILLED OUT COMPLETELY