1965 Capital Circle NE Impactbehavioralhealth.com Nancy Ryer Bass, MA, LMHC, MAC

Suite 102 Tonya Eaglin, MA

Tallahassee, FL 32308 Sharon Mason, MS, NP-C

(850) 671-4600 Sara Tiramalasetty, MD

(850 )878-2863 Angela Blount, MS

Kathryn Spencer Post, MS, EdS

Whitney Hyatt, MS, LMHC, ATR

Kenneth Brown, BA

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**AUTHORIZATION FOR RELEASE OF INFORMATION**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Rights**

* You may end this authorization (permission to use or disclose information) any time by contacting our office.
* If you make a request to end this authorization, it will not include information that may have already been used

Or disclosed based on your previous permission.

* You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
* You have a right to a copy of this signed authorization.
* If you choose not to agree with this request, your benefits or services will not be affected.

**Patient Authorization**

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, legal/court records, educational records, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the above identified patient. I authorize these agencies to share information by mail, phone, in person, fax and/or email contact. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

* **I hereby authorize** IMPACT BEHAVIORAL HEALTH **to RELEASE my protected health information (PHI) to :**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,** for the purpose

of continuity of care.

* **I hereby authorize** IMPACT BEHAVIORAL HEALTH **to OBTAIN my protected health information (PHI) from:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, for the purpose

of continuity of care.

**Disclosure Scope for PHI Release:**

Disclosure may include the following verbal or written information: (check all that apply)

\_\_\_Face Sheet \_\_\_\_History & Physical

\_\_\_Laboratory/ diagnostic testing results \_\_\_\_School Information

\_\_\_Discharge Summary \_\_\_\_Medication Records

\_\_\_Behavioral Health/Psychological Consult \_\_\_\_Psychosocial Assessment / Family History

\_\_\_ER record report \_\_\_\_Psychiatric Evaluation

\_\_\_Substance Abuse treatment records \_\_\_\_HIV/AIDS lab results & treatment history

\_\_\_Progress & Case Notes \_\_\_\_Summary of treatment records & contact dates

\_\_\_Psychological Evaluation/ Testing Results \_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Information necessary to identify, diagnose, prognosis, or treatment for mental health, substance abuse (alcohol/ drug use), and any other relevant information for the purpose of treatment.

All information I hereby authorize to be obtained from the above identified source will be held strictly confidential and cannot be release by Impact Behavioral Health, LLC without my written consent. I understand that this authorization will remain in effect for:

\_\_\_ One year, or

\_\_\_The period necessary to complete all transactions on accounts related to services provided to me.

I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been take which was based on my consent, I may withdraw this consent at any time. If client is a minor child, I verify that I am the legal guardian/ custodian of this child.

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*Signature of Client/Legal Guardian or Legally Authorized Representative Date*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness Date*