Peace River Center®
COMPASSIONATE PEOPLE, POSITIVE IMPACT

Phone: 863-519-0575
FAX: 863-499-2528

Authorization for Release or Exchange of Confidential Information

Patient/Client: **Clinical Record#:**
DOB: **Social Security #:**

This form authorizes Peace River Center, to release or exchange information as indicated below, regarding the client's contacts/ treatments in accordance with Florida Statutes and Federal Administrative Rules and Regulations to/from:

I hereby Authorize (Name):_____

Street Address:_____

City:_____ State:_____ **Zip:**_____

Phone:_____ **Fax:**_____

I also authorize the following entities as indicated by a check mark:

- ☐ Social Security Administration:550 Commerce Drive Lakeland, FL 33813, 800-325-0778
- ☐ Lakeland Regional Health:1324 Lakeland Hills Blvd. Lakeland, FL 33805, 863-687-1100
- ☐ Department of Children & Families: 4720 Old Highway 37 Lakeland, FL. 33815, 863-534-7100
- ☐ Lakeside Pediatrics:2929 Lakeland Hills Blvd., Lakeland, FL 33805, 863-688-3550

Purpose of Disclosure: ☐ Legal ☐ Disability ☐ Continuity of Care ☐ Self Other:_____

Information may be Received as follows:

☐ Psychiatric/Psychological ☐ Substance/Alcohol Abuse ☐ Medical/Hospital Information
☐ HIV/AIDS ☐ Verbal Communications ☐ None Other:_____

Information may be Released as follows:

☐ Psychiatric/Psychological ☐ Substance/Alcohol Abuse ☐ Medical/Hospital Information
☐ HIV/AIDS ☐ Verbal Communications ☐ None Other:_____

Costs of Reproducing Medical Records: PRC reserves the right to charge a reasonable cost for reproducing records, set forth by Florida Administrative Code 64B8-10.003. By signing this Release of Information form, I understand that I may be responsible for any costs incurred.

Notice of Prohibition on Re-disclosure: This information has been disclosed to you from records protected by Federal Rules governing confidentiality rules (42 CFR Part 2) and Florida Statutes (394.459, 396.112, 397.053, 381.609, 455.2416, 90.503, 90.242, and 45 CFR Part 160-164). The Federal Rules and State Statutes prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains.

Information used or disclosed pursuant to this authorization may be subject to Re-disclosure by the recipient and no longer be protected by the rules above. Peace River Center is released from all legal liability that may arise from the release of information requested. I understand I have the right to refuse this authorization or revoke it at a later date by submitting a written notice to the address above. I understand that I am not required to sign this authorization in order to receive treatment. When exchanging information where the patient/client is involved in treatment with other agencies/professionals to assist in coordinating treatment, this authorization may include verbal, written and/or electronic communication.

This authorization is valid for 1 year unless otherwise specified:

Please answer the following questions if release or exchange of information is sought by the parent/legal guardian of a minor only:

1. Has patient/client been emancipated?	Yes	No
2. Has patient/client ever been convicted of a crime as an adult?	Yes	No
3. If the answer to question 2 is yes, is patient/client in the custody or under the supervision of the State Dept. of Corrections?	Yes	No
4. Has the patient/client ever been removed from your legal custody?	Yes	No

If the answer to any question is yes, do not release. Contact Health Information Services for guidance.

Patient/Client-signature: **Witness:** **Parent/Guardian Signature:**

Print-Parent/Guardian Name:

Date:

Relation to Patient/Client: