CHILDREN'S HOME SOCIETY OF FLORIDA

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I _____, hereby authorize the release of confidential information consisting
(Print name of client/parent/guardian)

of *(Psychiatric Records or Information, Psychiatric Medications, Drug/Alcohol Records or Information, HIV or AIDS Information, Medical Records or Information; Social History; Psychological Records or Information, Educational or School Records, Assessments, Service/Treatment Plans, All records of Children's Home Society of Florida etc.)*
Indicate the specific information that may be released:

_____

_____

_____

From:

Individual /Organization:

Address: _____

_____

To:

Individual /Organization: _____

Address: _____

_____

regarding *(check one or both)* ☐ myself _____
(Date of birth)

☐ the following minor child(ren):

Minor child _____ _____
(Print child's name) *(Date of birth)*

Minor child _____ _____
(Print child's name) *(Date of birth)*

Minor child _____ _____
(Print child's name) *(Date of birth)*

Minor child _____ _____
(Print child's name) *(Date of birth)*

for the purpose of assisting with diagnosis, treatment, rehabilitation and/or delivery of other services.:

I understand that my treatment, payment for services, enrollment in services or eligibility for services will not be affected by my refusal to sign this form.

I understand that the information that is released by signing this form may be further disclosed by the recipient and is then no longer protected by the Federal code as required by 45 CFR 164.508(c)(2)(iii).

This consent or authorization for release of information shall be effective the date of signature and shall expire one (1) year from the date of signature or may be revoked at any time, provided I notify the program in writing to this effect. Revocation has no effect on action previously taken.

SIGN SECTIONS THAT APPLY

Consumer

_____
Printed name

_____
Signature

_____
Date

Parent or Guardian of Minor child

_____
Printed name

_____
Signature

_____
Date

If the consumer has difficulty understanding or reading this document, please print the name of the person who read this document or explained it to the consumer _____.

Client Funder/Medicaid Number: _____