Behavioral Health Centers of Sarasota
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Authorization to Disclose Protected Health Information

Patient Name: _____ **Date of Birth**: _____

This authorization will permit release of information:

To ____ From ____

_____

Name Address

_____

Phone Fax

_____

Check all that apply:
( ) Admission and Discharge Summary
( ) Prescription History
( ) Reports of any Psychological Testing
( ) Progress Notes for Medication Management
( ) Laboratory Results
( ) Other: _____

The purpose for which this protected health information is being disclosed is:
( ) Continued treatment
( ) Other: _____

This authorization does **NOT** authorize the disclosure of psychotherapy notes. Psychotherapy notes require a separate authorization for disclosure because of the higher standard of privacy protection.

Consent is subject to revocation by the patient at any time in writing. Consent may not be withdrawn for disclosure made prior to revocation. Once released, Behavioral Health Centers of Sarasota has no control over use of records. Unless the person or organization authorized to receive this information is a health care provider or health plan covered by the Federal HIPAA Privacy Regulations, the patient health information disclosed may no longer be protected from further disclosure by Federal or State Law.

Records given directly to a patient will no longer be covered by the HIPAA Privacy Regulation. Furthermore, by receiving your own records, you agree to take full responsibility for them and Behavioral Health Centers of Sarasota will no longer be responsible for any information that may be released into the public about you and/or your medical records. Should you choose to take your medical records with you, there will be charge of $1.00 per printed page.

This authorization shall expire on: _____

Signature of Patient/Patient's Representative: _____
Printed Name of Signee: _____
Relationship to Patient: _____ Date: _____