Florida Psychiatry Associates

1555 NW St. Lucie West Blvd., Suite 201, Port St. Lucie, FL. 34986; Phone 772-878-7216, FAX 772-878-7218; www.flpsychiatry.com

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient Name:_______________________________________ **DOB**:__________________________
(Please print clearly)

Initial each format to be released: ______ Verbal _____ Written _____ Electronic (Fax / or other data format*)

This information is to be released to:

Name of Organization/Provider: ____

Phone: ___________________________ **Fax**: ____

I authorize any FPA staff member who may be directly or indirectly involved in my care to disclose confidential information about me to the persons/agencies listed below. This confidential information includes, but is not limited to: my psychological/psychiatric history, my drug and alcohol use history, medical history, family history, legal and financial status, treatment history, results of diagnostic tests (including HIV results), urine tests, and clinical progress reports, current or planned treatment I may receive, all aspects of my treatment and clinical progress, and all other information deemed important by the staff of FPA to assist with my treatment and/or other personal or business matters including but not limited to comprehensive medical care, insurance reimbursement, legal action, regulatory action, marital conflict, child custody, etc. Any release of mental health and substance abuse information must be pursuant to F.S.A. §394.4615, F.S.A. §455.667, F.S.A. 397.501(7), 42 U.S.C. §290dd-2, 42 C.F.R. Part 2 and 45 C.F.R. §164.506. Only the above specified persons or agencies will receive this information. There are other special restrictions that apply to the release of information regarding, but not limited to, the reporting of HIV (F.S.A. §384.25), child abuse (F.S.A. §39.201), and elderly or disabled abuse (F.S.A. §415.1034).

PROHIBITION ON RE-DISCLOSURE: This information has been disclosed from records whose confidentiality is protected. Federal and state rules prohibit anyone from making any further disclosure of this information unless the patient provides specific written authorization for the subsequent disclosure of this information or as otherwise permitted by 42 C.F.R. Part 2 or F.S.A. §394.4615. Florida law requires that any person, agency or entity receiving this information shall maintain such information as confidential and exempt from the provisions of the public law (F.S.A. §394.4615(6). Any facility or private mental health practitioner who acts in good faith in releasing information pursuant to F.S.A. §394.4615 or other Florida statute is not subject to civil or criminal liability for such release.

REVOKE: I understand and acknowledge this consent expires when I am no longer an active patient with Florida Psychiatry Associates, LLC (FPA) or if revoked by me in writing and that I may do so at any time for any reason except to the extent that: 1) this information is deemed necessary to protect my personal safety and/ or the safety of others who may be seriously affected by my behavior; 2) disclosure has already occurred; or, 3) any action that relies on this disclosure has already been taken and/or is in progress.

*I understand by approving the release of information in the form of a facsimile (FAX), confidentiality cannot be assured, my initials indicate that I accept that risk & that confidentiality may be breached if I fail to properly safeguard my electronic form of data storage.

___________________________________ ____ _____________

Printed name of Patient | Signature of Patient, Guardian or POA Representative | Date