Soundside Wellness
CONSULTANTS

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I understand the information to be released from (my) records: _____
PRINT NAME OF CLIENT

_____
CLIENT BIRTH DATE

I authorize SOUNDSIDE WELLNESS CONSULTANTS/ _____ to exchange
Name of Provider / Facility

with_____ _____
Name of Person or Agency **Address of Person or Agency**

The following information as initialed below (and dated if applicable):

_____ Psychiatric/Psychological Evaluation
_____ Treatment Recommendations
_____ Test Results
_____ Psychiatric/Psychosocial History
_____ Treatment Plan(s)
_____ Day Treatment Program Summaries
_____ Certification of Self-Preservation
_____ Progress Notes (Psychiatric/Medical)
_____ Discharge Summary
_____ Status of Patient in Treatment
_____ Medication Regimen and/or History
_____ Medical Evaluation
_____ Results of Physical Exams
_____ Emergency Room Reports
_____ History and Physical Information Forms
_____ Results of Urinalysis and Breath Tests
_____ Consultation/Referral Report for _____
_____ Surgical Reports for/dates _____
_____ Laboratory Test results for/test _____
_____ Medical Test results for/test _____
_____ Synopsis, in lieu of _____
_____ Other_____

The sole purpose for the release of the above information is: CONTINUITY OF CARE_____
_____ **PLEASE FAX RECORDS TO 850-833-7470**_____

I understand that I may revoke this authorization at any time except for that action which has already been taken to comply with it and that my records are protected under State laws regarding mental health treatment and Federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, and Chapter 397, Florida Statutes. I also understand that I may take back my consent at any time or otherwise it will automatically expire: *Circle one*: (1) on satisfaction of the need for disclosure; or (2) from 90 days from the signature hereon; or (3) _____ **(Date Supplied by Client/Patient).**

_____ _____
SIGNATURE OF CLIENT/PATIENT **DATE**

OR

_____ _____
AUTHORIZED SIGNATURE FOR CLIENT/RELATIONSHIP **DATE**

_____ _____
WITNESS **DATE**

Addendum: Per Florida Statute, clients requesting copies of their medical record will be provided with a summary of treatment **or** a copy of the entire record can be sent directly to a professional of the client's choice. Please note that a separate, specific HIV authorization must be obtained prior to release of HIV information.