BOYS TOWN Central Florida

Behavioral Health Clinic
975 Oklahoma Street
Oviedo, Florida 32765
Phone: 407-588-2170; Fax: 407-588-2171

Authorization to Release Information

Client Name: _____ Date of Birth: _____

I hereby authorize Behavioral Health Clinic staff to:
☐ release and/or ☐ request information from the record of the above-named client.

To/From: _____
Name of agency or individual (e.g., psychiatrist, school personnel, therapist)

Phone: _____ Fax: _____

Purpose for Disclosure:

☐ To permit coordination and collaboration of care ☐ Other: _____

Information to be Released:

☐ Psychological Evaluation
☐ Treatment Summaries
☐ Other: _____

Information Requested:

☐ Psychological/Psychiatric Evaluation
☐ Treatment Summaries
☐ Progress Notes
☐ Substance Abuse Evaluation
☐ Discharge Summary
☐ Medical Evaluation
☐ Prescribed Medications
☐ History/Physical
☐ Educational Records/Reports
☐ Other: _____

At any time, I may revoke this consent in writing. I understand that the revocation will not be effective retroactively for information exchanges that have already occurred. Unless otherwise noted, this consent expires 6 months from the date of my signature below.

NOTICE TO RECIPIENTS: You are prohibited from disclosing the information to any other party and are required to destroy the information after the stated need has been fulfilled. This information has been disclosed to you from records which may be protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Father Flanagan's Boys' Home, its employees, and its officers are hereby released from any legal liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature of client (if not a minor, unless receiving substance use services) Date

_____ _____
Signature of parent or legal guardian (if client is a minor) Date