CenterPlace Health
AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ _____
Last First MI Maiden or other Name

Date of Birth: _____ **Address:** _____ **Phone:** _____

PLEASE CHECK OFF WHICH DEPARTMENT IS: ☐ ***REQUESTING INFORMATION*** ☐ ***RELEASING INFORMATION***

Dept.ID	Dept. Name	Dept. Address City/State	Fax
☐ 02	Ringling Family Medical	2200 Ringling Blvd, Sarasota, FL 34237-61021	855-212-2456
☐ 12	Ringling Pediatric	2200 Ringling Blvd, Sarasota, FL 34237-6102	855-212-4561
☐ 13	Ringling Behavioral Health	2200 Ringling Blvd, Sarasota, FL 34237-6102	855-225-3985
☐ 04	Children's Health	1750 17th Street, Sarasota, FL 34234-6102	855-212-2465
☐ 11	OB / GYN	1750 17th Street, Sarasota, FL 34234-6102	855-212-4438
☐ 03	North Port Family/Pediatric	6950 Outreach Way, North Port, FL 34287-3405	855-212-2460
☐ 09	North Port OB /GYN	6950 Outreach Way, North Port, FL 34287-3405	855-212-4422
☐ 10	North Port Behavioral Health	6950 Outreach Way, North Port, FL 34287-3405	855-212-4423

INFORMATION TO BE RELEASED TO ☐ **INFORMATION REQUESTED FROM** ☐ **Please list below who can receive/provide information**

_____

_____

INFORMATION TO BE DISCLOSED: (Initial Selection)

☐ General Medical Record(s), including STD and TB ☐ Progress Notes ☐ History and Physical Results ☐ Immunizations ☐ Consultations

☐ Family Planning ☐ Prenatal Records ☐ Diagnostic Test Reports (Specify Type of test(s) _____

☐ Other: (specify) _____

I SPECIFICALLY AUTHORIZE RELEASE OF INFORMATION RELATING TO: ***(Initial Selection)***

☐ HIV test results for non-treatment purposes ☐ Substance Abuse Service Provider Client Records ☐ Early Intervention ☐ WIC

☐ Psychiatric, Psychological or Psychotherapeutic notes ☐ Other: (specify) _____

PURPOSE OF DISCLOSURE: ***(Initial Selection)***

☐ Continuity of Care ☐ Personal Use ☐ Other: (specify)_____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

_____ _____
Client/Representative Signature Date

_____ _____
Printed Name Representative's Relationship to Client

_____ _____
Witness (optional) Date