Toll Free: (888) 255-9817
Website: www.tdiworks.org

AUTHORIZATION TO DISCLOSE INFORMATION

ALL BLANK SPACES MUST BE FILLED IN PRIOR TO PERSON SIGNING AUTHORIZATION

NAME_____ DOB_____ SS # _____

I hereby request and authorize_____to
(Name of agency sending information)
release general medical as well as psychiatric/psychological information related to my mental health treatment in accordance with Florida Statues and federal HIPAA law. I further authorize the agency releasing the information specified below to do so in written and/or verbal form.

Information to be released:

Psychiatric Evaluation, Medication Record, Treatment Plans, Discharge Summary, Narrative Summary, Psychosocial Assessment, History and Physical Examination, Progress Notes (Dr. and Clinician), Consultation Reports, Psychological Testing, Other (explain): _____

TO:

Name of Agency or Individual _____

Address _____

For the purpose of: _____

_____I authorize the release of alcohol and drug abuse information, if present, whose confidentiality is protected by Federal Law. Federal regulations (42CFR, Part2) prohibits making any further disclosure of it without the specific written authorization of the undersigned, or as otherwise permitted by such regulation.

_____The release of any information concerning AIDS, HIV, and AIDS Related Complex and the performance of any tests, counseling and the results and treatment thereof are also authorized. I understand that my records have a privileged and confidential status. I am waiving that status for the purpose contained within this authorization.

_____I give my permission for the Diversity Initiative, Inc. Staff to speak with employers, family members or support system listed above to enhance my recovery.

_____I understand that this consent is revocable upon written notice, except to the extent that action has already been taken on this authorization. This authorization shall remain in force for a reasonable time to accomplish the purpose for which it is given or will expire in one year from the consumer's signature as it appears below.

I understand that I have the right to refuse to sign this authorization or to modify any section of it prior to signing by crossing out the information I do not want released and initialing the change.

_____ _____
Consumer Signature Date

_____ _____
Parent, Legal Guardian, or Authorized Rep. Date

_____ _____
Witness Date

****This information has been disclosed to you from the records whose confidentiality is protected by law. Any further re-disclosure is strictly prohibited.*