TREASURE COAST COMMUNITY HEALTH

Authorization for Release of Behavioral Health Information
772-257-8224 (TCCH)

Patient's Name: _____ Chart #: _____
Date of Birth: _____ SS#: _____

Form in which Information is to be released: Verbal Written Both Fax

I hereby request and authorize to release the following information from my medical records:
Name of Organization/Provider: _____
Address: _____
Phone #: _____ Fax: _____
Be specific – "All Medical Records" is not sufficient: _____

This information is to be released to:
Name of Organization/Provider: _____
Address: _____
Phone #: _____ Fax: _____
This released will cover treatment service dates from _____ to _____
The purpose of releasing this information is to: _____
Please note: Only minimally necessary information will be released.

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. §164.508. 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 disable abuse (F.S.A. §415.1034). You have the right to inspect and/or copy protected health information to be used or disclosed as provided in 45 C.F.R. §164.524.

PROHIBITION ON REDISCLOSURE: 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. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. (42 C.F.R. 2.32). 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 records 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.

If this authorization releases protected information to a third party payer, it is understood that payment may result.

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 the risk that confidentiality may be breached when FAXING information. Client or Rep.
Initials _____

I understand that this authorization will expire 1 year from the date of my signature below; I understand that I have the right to refuse to sign this authorization and that treatment will not be withheld on condition that I sign this form. I further understand that I may revoke my consent by completing the bottom of this authorization at any time prior to the release of any information. I understand Treasure Coast Community Health, Inc. will not be held liable for any information released prior to my revocation.

I hereby release Treasure Coast Community Health, Inc. and its employees from any and all liability that may arise from the release of information I have directed.

Patient's Signature: _____ Date: _____
Required for all patients 18 years & older

Signature of Parent or Legal Guardian: _____ Date: _____
(Required for all patients under the age of 18 unless otherwise allowed by law. If not parent, legal rep documentation must be supplied)

TCCH Staff Member Signature: _____ Date: _____

☐ Fellsmere
12196 County Road 512
Fellsmere, FL 32958
Fax: 772-252-3263

☐ Central
1553 US Highway 1
Vero Beach, FL 32960
Fax: 772-675-9986

☐ Sebastian
13505 US Highway 1
Sebastian, FL 32958
Fax: 866-880-8208

☐ Oslo
1545 9th Street SW
Vero Beach, FL 32962
Fax: 772-408-9624

☐ V787
787 37th St. Suite 140
Vero Beach, FL 32960
Fax: 772-237-3255

☐ Gifford
4675 28th Ct.
Vero Beach FL, 32967
Fax: 866-893-9105