Charlotte Behavioral Health Care, Inc.
AUTHORIZATION TO REQUEST RELEASE OF INFORMATION

First Name	MI	Last Name	DOB	SSN
_____	_____	_____	_____	_____

I authorize **CHARLOTTE BEHAVIORAL HEALTH CARE, INC., 1700 Education Avenue, Punta Gorda, FL 33950** or any of its subsidiaries or affiliates and the clinician(s) performing services on behalf of CBHC in connection with my treatment to:
□ **Disclose information to:** □ **Obtain information from:** ***(If information is to be shared, check both boxes.)***

Name of Person/Agency: _____

Phone Number _____

Person/Agency Address: _____
Street City State ZIP

Fax Number _____

Information may be disclosed verbally, in writing, or by fax. *(Check box □ and initial _____)*

INITIAL what is to be released:
MENTAL HEALTH RECORDS (Not including Substance Use)
□ Case Management Assessment Adult/Child ____
□ Comprehensive Assessment SA/ MH/ Adult/ Child ____
□ Psychiatric Evaluation and Med Services ____
□ Lab Reports, Diagnostic Tests, etc. ____
□ Discharge Summary(ies) ____
□ Crisis Stabilization Unit ____

□ Other _____

SUBSTANCE USE RECORDS
□ Substance Use Records with NO restrictions ____
□ Substance Use Records limited to the following: ____
□ Attendance Records ____
□ Group Notes ____
□ Psychiatric Eval and Med Services ____
□ Residential and/or Detox Services ____
□ UDS & Lab Results ____
□ Comprehensive Assessment ____
□ Discharge Summary ____

This information for which I am authorizing disclosure will be used for the following purpose: (must be completed to be valid)
□ To permit continuity of care
□ To keep EAP/referral source informed
□ My personal records
□ To maintain family involvement in treatment
□ Legal reasons (i.e., disability, accident, etc.)

I understand that this form may be used to release information related to mental health treatment, substance use treatment and may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information regarding Hepatitis A, B, C.

Patient's Initials _____

I understand the following. I am under no obligation to sign this form and my refusal to sign will not affect my ability to obtain treatment. This release not only covers the provision and receipt of all records maintained by Charlotte Behavioral Health Care, Inc., but also authorizes any member of the staff, employee of, or entity contracting with Charlotte Behavioral Health Care, Inc. to discuss the case, treatment and records with the person authorized to receive information either in private conversations, depositions, or court testimony. My substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act. Any information disclosed to you was taken from the records of which the confidentiality is protected by State (394.459, 397.053, 381.609), (455 and 90) and/or Federal Law (42 CFR, Part 2) (45 CFR 160-164). 42 CFR, Part 2 prohibits Charlotte Behavioral Health Care, Inc. from making any further disclosure without specific written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any patient with a substance use disorder. Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided.

Revocation Notice: I may revoke this information in writing, at any time prior to the release of the information specified above. Disclosures made in good faith prior to revocation do not constitute a breach of confidentiality.

_____ (Initial here) I have read and fully understand the terms of this release and waiver.

Signature of Patient or Legal Representative:

_____ _____
Patient Name Date

This authorization will expire one year from date signed or upon termination (discharge) of treatment with all providers of CBHC. I understand authorizing the use or disclosure of the information identified is voluntary. I need not sign this form to ensure health care treatment.

If signed by legal representative, relationship to patient: _____

Paper documentation establishing relationship is provided: □ Yes □ No _____

Staff/Witness Signature _____ _____
Staff/Witness Name Date

CBHC Medical Records Phone: 941-639-8300, ext. 2316 Fax: 941-575-1865

Florida Law allows us to charge a reasonable fee for copying records.
I would like to receive my records:
_____ Paper $1.00 per page OR _____ CD $3.00

This policy is posted outside of the Records Department, and we can provide a copy for you if you wish.
If you have questions or concerns, please ask to speak with the Medical Records Manager.

Our hours of operation for authorizations/releases/consents are 8:30 AM to 5:00 PM, Monday through Friday.

For questions or concerns, please call 941-639-8300, ext. 2316.
Please leave your name and number, and someone will return your call within 24 hours Monday-Thursday.
Calls after 4 PM on Friday will be returned on the following Monday.

Florida Law states we have 30 days to make records available.
You will be notified if that is not possible.