**Florida Counseling and Evaluation Services (FLCES)**
PO BOX 54723, Jacksonville, FL 32245
Tel.: 904-239-3677 – Fax: 904-866-4029

# Authorization to Release Information (ROI)

**Patient Name:** _____ **DOB:** _____

**Address :** _____ **Telephone:** _____

By marking (**X**) on the applicable line(s)/field(s), I hereby authorize my provider and Florida Counseling and Evaluation Services (FLCES) to:

**__ Release and __ Exchange my personal/health information to/with:** **__ Obtain my personal/health information from:**
*** Note:** Minimum information **required**: Name, City, and Contact Phone or Fax No. – **preferred**:* All available information to aid in proper records routing. **

_____ _____

_____ _____

_____ _____

**Type of communication/exchange of information/records authorized, check EITHER entire record OR summary, then additional fields:**

___ Entire Record (including psychotherapy notes) **OR** ___ Summary Only ___ Verbal Communication ___ Other: _____

___ Specific Date(s) of Service Requested: _____ to _____ ___ *Obtain **ALL** records for personal use (fee applies)*

I authorize to discuss my health care/treatment records (or my child's treatment, *where applicable*) with the releasing or obtaining entity.

Information I **DO NOT** want released pursuant to this authorization: _____

I hereby acknowledge awareness that records may contain information related to mental health (including therapy notes), substance abuse (federal law prohibits the person or organization to whom disclosure is made from making any (further) disclosure of substance abuse treatment information unless such disclosure is expressly permitted by this written authorization of the person to whom it pertains or as otherwise permitted by Code of Federal Regulations 42 C.F.R. Part 2), and communicable diseases (including test results related to HIV/AIDS), and I specifically authorize the release of such information by signing this authorization and initialing the line that following this statement. _____ **(Initials of Patient)**

I understand that this authorization will remain in effect for one (1) year, but I may revoke it at any time in writing. I further understand that any such revocation will not apply to any information already released/exchanged pursuant to this authorization. I understand that I am not under any obligation to sign this authorization and that my ability to obtain treatment from FLCES or any entity affiliated with Florida Counseling and Evaluation Services will not depend in any manner on whether or not I sign this authorization. I understand that unless deemed clinically necessary by my FLCES provider to support my treatment, the completion of this form may not automatically initiate a request, release, or exchange of any record, and I should verbalize to my clinician or his/her representative when I want certain records to be requested, released, or exchanged, so such request can be entered into my medical chart record.

I understand that I may obtain a copy of this authorization. I understand that the disclosing entity or person may charge me reasonable cost-based fees for any record it produces and releases pursuant to this authorization including records requested for my own personal use. The disclosing entity/person may waive such fees for records provided to another health care provider for continuing care.

I understand that although federal or state law may prohibit the recipient from re-disclosing information provided pursuant to this authorization, the disclosing entity/person may not have any control over the recipient, and, therefore, cannot guarantee that the recipient will not re-disclose such information. I hereby release the disclosing entity or its respective representatives and affiliates from any and all liability related to (a) the reliance upon this authorization, or (b) the release of information pursuant to this authorization.

By signing below, I understand this authorization form in its entirety and have been provided with the opportunity to ask my health care provider or its representative or affiliates for additional clarification. I authorize the person or entity named above to release health care related information about me as described above. I agree that a signed photocopy in lieu of this original may serve as a valid release-of-information form.

**Patient Signature:** _____ **Date/Time:** _____

*If patient is a minor or incapacitated adult:*

Representative Signature: _____ Date/Time: _____

Relationship to Patient: _____ Printed Name: _____

**Witness Signature:** _____ **Date/Time:** _____