

This is an authorization for release of information regarding the below identified individual:

Client Name:	DOB:	Program Name: BFSS		
Program Address: 4095 US Hwy 1	City: Rockledge	State: FL	Zip Code: 32955	

The Effective Date of this form is: _____. (Please note that if the signatures at the end of this form are dated after the Effective Date noted above, the latest signature date shall be the Effective Date.)	This form will expire on: _____. (The Expiration Date above may not be greater than one year from the Effective Date. If the date above is blank, this form will expire one year from the Effective Date.)
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I hereby authorize Eckerd Connects to:

- A.** Release and/or obtain, or not permit the below protected and confidential information regarding the above named Client as directed below:

INFORMATION	SPECIFIC DOCUMENTATION	RELEASE and/or OBTAIN, No or NA			
Discharge Summary		Release To <input type="checkbox"/>	Obtain From <input type="checkbox"/>	No <input type="checkbox"/>	NA <input checked="" type="checkbox"/>
Educational/Vocational Plans or Records		Release To <input type="checkbox"/>	Obtain From <input type="checkbox"/>	No <input type="checkbox"/>	NA <input checked="" type="checkbox"/>
HIV/AIDS Related Information		Release To <input type="checkbox"/>	Obtain From <input type="checkbox"/>	No <input type="checkbox"/>	NA <input checked="" type="checkbox"/>
Medical History		Release To <input type="checkbox"/>	Obtain From <input type="checkbox"/>	No <input type="checkbox"/>	NA <input checked="" type="checkbox"/>
Physical Examination		Release To <input type="checkbox"/>	Obtain From <input type="checkbox"/>	No <input type="checkbox"/>	NA <input checked="" type="checkbox"/>
Progress Reports		Release To <input type="checkbox"/>	Obtain From <input type="checkbox"/>	No <input type="checkbox"/>	NA <input checked="" type="checkbox"/>
Psychological Evaluation/Reports		Release To <input type="checkbox"/>	Obtain From <input type="checkbox"/>	No <input type="checkbox"/>	NA <input checked="" type="checkbox"/>
Service/Treatment Plan		Release To <input type="checkbox"/>	Obtain From <input type="checkbox"/>	No <input type="checkbox"/>	NA <input checked="" type="checkbox"/>
Social History		Release To <input type="checkbox"/>	Obtain From <input type="checkbox"/>	No <input type="checkbox"/>	NA <input checked="" type="checkbox"/>
Substance Use (see below NOTE)		Release To <input type="checkbox"/>	Obtain From <input type="checkbox"/>	No <input type="checkbox"/>	NA <input checked="" type="checkbox"/>
Other	Information regarding current/past housing status including conversations	Release To <input type="checkbox"/>	Obtain From <input type="checkbox"/>	No <input type="checkbox"/>	NA <input type="checkbox"/>

NOTE: A separate Authorization must be completed to have this information released for each of the following:

- Any exchange of Psychotherapy records (i.e., separately kept records of a mental health professional documenting/analyzing the contents of counseling sessions) must be authorized using the separate authorization form for Psychotherapy Records. (If Eckerd Connects must exchange psychotherapy records as well as other information listed above, please complete both this authorization form and the authorization form for psychotherapy records.)
- Only Substance Use records pertaining to involuntary commitments and/or situations where state and federal law require parental consent for treatment are covered by this Authorization.

All other Substance Use records require a separate Substance Use specific authorization form signed only by the client.

- B.** With the following party:

Name or Title: _____

Agency Name (if applicable): _____

Address: _____

Phone Number: _____

Email Address: _____

Fax Number: _____

This information may be used only for the specific purpose of (check as many of the following that are applicable):

- Development and Implementation of Individualized Service Plan / Plan of Care / Treatment Plan
- Coordination of Services
- Referral for New Service
- Monitoring of Services
- Parent Request to Release
- Client (Over 18 years of age) Request to Release
- Other (please specify): To obtain information regarding client's current and/or potential housing to include rent payment transaction history and current housing status.

Any limitations that I impose on Eckerd Connects with respect to this Authorization are stated as follows:

My signature below acknowledges that:

- I have been informed of the specific type of information that has been requested and give my consent voluntarily.
- The purpose of releasing information and confidentially has also been explained to me.
- I understand that the provision of services is not based on my decision concerning the release of information or signing this Authorization.
- I understand that my records are protected under Federal and State regulations governing the confidentiality of Medical Records including Mental Health, STD's (including HIV-AIDS), and Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).
- I have been informed and understand that information disclosed or received pursuant to this Authorization may be subject to redisclosure by the recipient and no longer be protected by Federal and State law.
- I understand that this Authorization may be revoked at any time with written notice to Eckerd Connects - Attn: Records Custodian, 100 Starcrest Drive, Clearwater, FL 33765 - except to the extent that the information has already been released based upon this consent.
- I understand that this Authorization is not automatically renewable. Per my request, this Authorization will expire on the date noted above unless that space is left blank, then this Authorization will expire exactly one year from today. Under no circumstances will this Authorization last longer than one year from today. Except as required by law, this Authorization will remain valid through the expiration date above, unless effectively revoked in writing by me, before this date.
- I have read this Authorization or it has been read to me, and I understand its content to my satisfaction.

Client: _____
(Signature) (Print) (Date)

Legal Guardian: _____
(Signature) (Print) (Date)

Legal Guardian's relationship to Client: _____

A copy of this Authorization has been offered to the following parties signing it: Client , Parent/Guardian .
The copy was **accepted** / **not accepted** by the client or Parent/Guardian.