**CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION**
**BEE RIDGE FAMILY PRACTICE**

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***PLEASE READ & COMPLETE THE ENTIRE FORM***

PATIENT NAME: _____

**DATE OF BIRTH _____/_____/_____ SOCIAL SECURITY NUMBER _____-_____-_____**

I authorize BEE RIDGE FAMILY PRACTICE/ENTITIES to: (check one)

☐ **SEND my records to:** ☐ **OBTAIN my records from:**

_____
Name of Physician or Facility

_____
Complete Street Address City State Zip Code

_____
Telephone #: Fax #:

I, _____ hereby authorize _____ to disclose to
(Name of Patient) (BEE RIDGE FAMILY PRACTICE or OTHER AGENCY WITH INFORMATION)
_____ the following information:
(BEE RIDGE FAMILY PRACTICE or OTHER AGENCY WITH INFORMATION)

*(Patient must initial each area of information, and may strike through and initial any specific information not to be released)*

| ____Clinical (Initial Here) | ____Medical (Initial Here) | ____Educational (Initial Here) |
|---|---|---|
| Psychiatric Evaluations | Medical History | IEP |
| Psychological Evaluations | Physical Examinations | Conduct |
| Biopsychosocial Assessments | Progress Notes | Psychological |
| Biopsychosocial Summary | Urine Tests | Report Cards |
| Treatment Plans | Medication Records | Attendance |
| Progress Notes | | Achievement Tests |
| Alcohol and/or Drug Treatment | | |

PURPOSE OF DISCLOSURE:
The purpose of this authorized disclosure is to coordinate treatment planning and services, and/or continuing care planning and referrals, and/or (Other Purpose: _____ )

I understand that my medical record may contain information about alcohol and / or drug treatment, mental health or psychiatric treatment, and or HIV / AIDS information. I do herein expressly and voluntarily consent to the disclosure of my health information, as specified, for the purpose of need as indicated above.
I understand that my records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the Regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it. This release expires only in the event I give written consent to revoke this "Release of Information" Form.

I understand that generally BEE RIDGE FAMILY PRACTICE may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____ _____
Date Signature of Patient/Authorizing Party

_____ _____
Signature of Witness Signature of Patient, Guardian or Other Authorized Representative