

**Adoption Related Services of Pinellas**  
**8800 49<sup>th</sup> Street N. Suite 212 ♦ Pinellas Park, FL 33782**  
**Fax: (727) 865-5178**

**AUTHORIZATION TO RELEASE / OBTAIN INFORMATION**

<b>CLIENT NAME</b>		<b>DATE OF BIRTH</b>	
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I am  the individual named above  
 a personal representative because the client is a minor, incapacitated or deceased

At Adoption Related Services of Pinellas, we strive to provide the most comprehensive treatment for you. Based on this, we are asking that you allow us to notify your Primary Care Physician (PCP) that you are now involved in mental health counseling and/or psychiatric services. In this way there is a continuum of care between practitioners who are committed to your care and well-being. Should you change or add providers we ask that you notify staff working with you so that we can update this information.

<b>I will authorize the exchange and release of the client's information</b> regarding <b>pertinent health and medical needs</b> between Adoption Related Services of Pinellas and the physician identified below. I am aware that disclosure of this information is for the purpose of coordination of care.	
PCP/Physician Name: _____	
Address: _____ City, State, ZIP: _____	
Phone: _____ FAX: _____	

Signature of Parent and/or Legal Guardian/Authorized Representative (circle all that apply)	Date
Signature of Parent and/or Legal Guardian/Authorized Representative (circle all that apply)	Date

This authorization is valid for:  a single disclosure, up to ninety (90) days  continuing disclosure for up to one year from the date of my signature as it appears above

- I understand that I do not need to sign this form in order to obtain enrollment, eligibility, treatment or payment for services.
- I understand that I have the right to refuse to sign this authorization and do not have to agree to authorize any use or disclosure.
- I understand that I can revoke this authorization at any time upon written notification to the provider named above. I further understand that revocation will not apply to information that has already been used or disclosed.
- I understand that I am authorizing the release of information from records whose confidentiality and privileged status is protected by Federal Regulations and Florida Statutes. However, the recipient of this information may not have to abide by the same federal and state privacy laws.
- I understand that I have a right to receive a copy of this authorization once I have signed it or may ask for a copy at any time by contacting the provider named above.

<b>The client currently does not have a PCP</b> and understand that it has been recommended that I obtain one. Once obtained, I will notify the clinician assigned to my case so that the above process can be completed.	
Signature of Parent and/or Legal Guardian/Authorized Representative (circle all that apply)	Date
Signature of Parent and/or Legal Guardian/Authorized Representative (circle all that apply)	Date

<b>I choose not to have the client's PCP or any other medical provider</b> notified of my treatment at Adoption Related Services of Pinellas. I understand that should I be prescribed medication or a significant event that warrants medical consultation arises, this issue will again be discussed with me. If necessary, a medical emergency permits use and disclosure of protected health information between health care providers for treatment (the provision, coordination, or management of health care and related services) for an individual including consultation between providers regarding a client and referral of a client.	
Signature of Parent and/or Legal Guardian/Authorized Representative (circle all that apply)	Date
Signature of Parent and/or Legal Guardian/Authorized Representative (circle all that apply)	Date