

**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 legal guardian/personal representative because the client is a minor, incapacitated or deceased

I give permission for Adoption Related Services of Pinellas to:

- Release information to:  
 Obtain information from:

**NAME OF PERSON / ORGANIZATION:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**PHONE NUMBER:** \_\_\_\_\_ **E-MAIL:** \_\_\_\_\_

The specific information to be disclosed is:

<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Assessment	<input type="checkbox"/> Communication <input type="checkbox"/> Phone <input type="checkbox"/> E-Mail <input type="checkbox"/> Written
<input type="checkbox"/> Medication Record	<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Narrative/Discharge Summary
<input type="checkbox"/> History and Physical Exam	<input type="checkbox"/> Psychological Evaluation	<input type="checkbox"/> Other (specify below):
<input type="checkbox"/> Educational Information	<input type="checkbox"/> Substance Abuse Treatment	

**FOR THE PURPOSE OF:**     Coordination of care     Other (specify):

I hereby authorize the disclosure of protected health information about the individual named above. I understand that my records have a privileged and confidential status. I am waiving that status for the purpose contained in this authorization.

- 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.

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 below

\_\_\_\_\_  
Signature of Client (If minor, Parent and/or Legal Guardian/Authorized Representative must also sign)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent / Legal Guardian / Authorized Representative (circle all that apply)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent / Legal Guardian / Authorized Representative (circle all that apply)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Counselor / Witness

\_\_\_\_\_  
Date