Mindful
Behavioral Healthcare

Authorization to Release or Obtain Confidential Information

Autorización para Divulgar u Obtener Información Confidencial

Patient Name (Nombre del Paciente):_____ Date of Birth (Fecha de Nacimiento): _____

Social Security # (Seguro Social):_____ Phone # (Teléfono): (_____) _____

I hereby authorize **Mindful Behavioral Healthcare** to ☐ **RELEASE or** ☐ **OBTAIN** information by mail or facsimile (fax) to/from:
(Por este medio autorizo ***Mindful Behavioral Healthcare*** a ☐ **PROVEER o** ☐ **OBTENER** información por correo o por fax a/desde:)

Name of Person/Organization (Nombre de Persona/Organización): _____

Address (Dirección): _____

City (Ciudad):_____ State (Estado):_____ ZIP (Zona Postal): _____

Phone (Teléfono): (_____)_____ Fax: (_____) _____

The following information is to be disclosed (La siguiente información debe ser provista)**:**

☐ Medical Records Dates (Fecha de Expedientes Médicos) From (Desde):_____ To (Hasta): _____
☐ Psychiatric Evaluation (Evaluación Psiquiátrica) ☐ Psychotherapy Notes (Notas de Psicoterapia) ☐ Psychological Assessment (Evaluación Psicológica)
☐ Substance Abuse Treatment (Tratamiento para Abuso de Substancias Controladas) ☐ Medication Management Notes (Notas de Administración de Medicamentos)
☐ Other (Otro) _____

For the purpose of (A los efectos de)**:** ☐ Continuing Care (Continuar Tratamiento) ☐ Personal (Personal) ☐ Other (Otro)_____

Notice to Patient and Recipient of Records
Aviso a los Pacientes y Receptor de los Récords

I understand that this form may be used to release information related to mental health treatment. I further understand that the information disclosed may include psychiatric, drug/alcohol abuse and/or HIV/AIDS data. I understand that I have the right to refuse to sign this Authorization or to rescind my consent at any time prior to the release of the information. If I do not revoke this authorization, it will automatically expire one year from the date of signature unless otherwise noted below.

(Entiendo que este formulario puede ser utilizado para divulgar información relacionada con el tratamiento de salud mental. Entiendo, además, que la información divulgada puede incluir abuso de alcohol y/o drogas psiquiátricas y/o datos sobre el HIV/AIDS. Yo entiendo que tengo el derecho de negarme a firmar esta Autorización o de rescindir mi consentimiento en cualquier momento antes de la publicación de la información. Si no revoco esta autorización, el plazo vencerá automáticamente un año desde la fecha de la firma a menos que se indique lo contrario a continuación.)

_____ Patient's Signature (Firma del Paciente)	_____ Printed Name (Nombre en Letra de Molde)	_____ Date (Fecha)
_____ When applicable, Signature of (Si aplica, firma de): ☐ Parent (Padre) ☐ Guardian (Guardián) ☐ Healthcare Surrogate/Proxy ☐ Power of Attorney (Poder de Abogado)	_____ When applicable, Signature of (Si aplica, firma de): ☐ Parent (Padre) ☐ Guardian (Guardián) ☐ Healthcare Surrogate/Proxy ☐ Power of Attorney (Poder de Abogado)	_____ Date (Fecha)
_____ Signature of Witness (Firma del Testigo)	_____ Printed Name of Witness (Nombre en Letra de Molde del Testigo)	_____ Date (Fecha)

This information has been disclosed to you from records protected by Federal confidentiality rules Florida Statues 394-459, 397.501, and /or 90.503 and 42 Code of Federal Regulations (42 CFR). This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for privacy of Individually Identifiable Health Information (Privacy Standards) 45 CFR, 160 & 164, and all federal regulations and interpretative guidelines promulgated there under. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and Florida Statues 394-459, 397.501, and /or 90.503. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I have been informed that this authorization is subject to revocation by me at any time except to the extent that Mindful Behavioral Healthcare has already taken action in reliance on it. Once the requested protected information is disclosed, the Privacy Regulation may no longer protect it if the PHI's recipient re-discloses it. Further, I understand that despite all care taken, information is occasionally received by a party not intended to be the recipient. I hereby release Mindful Behavioral Healthcare from all liability should this information be received by someone other than the above-intended recipient.