

**Authorization for Release of Information**

**CARE COORDINATION**

This form authorizes Central Florida Behavioral Health Network (CFBHN) to disclose behavioral health treatment information to the organizations within its network that serve clients enrolled in Care Coordination services.

**Client Name** (Please print):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth**:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Social Security Number**:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Organization Providing**

**Care Coordination Services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Care Coordinator**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Care Coordinator**

**Contact Information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Authorization:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Expires 24 months from Date of Authorization*

**Purpose of Authorization:** Coordination of care, treatment and discharge planning

**I authorize Central Florida Behavioral Health Network to release to**:

1. The organization providing my Care Coordination services:

* Dates of Crisis Stabilization Unit treatment maintained in its records, including the name(s) of the service provider(s);
* Dates of Detoxification Unit treatment maintained in its records , including the name(s) of the service provider(s);
* Dates of Residential treatment maintained in its records , including the name(s) of the service provider(s);

2. The Network Service Providers listed on page 2 of this document, in the event of my admission to

 services of their agency,:

* An acknowledgement of my enrollment in Care Coordination services;
* The name of my Care Coordinator and their contact information;

Please indicate the Network Service Providers to which you give CFBHN permission to release the information outlined on the previous page of this document.

*Please initial*

 I authorize the release of this information to any of the Network Service Providers

 listed below:

Agency for Community Treatment Services (ACTS) Gulf Coast Jewish Family Services, Inc.

BayCare Behavioral Health, Inc. Northside Mental Health Center, Inc.

Centerstone Operation PAR, Inc.

Charlotte Behavioral Health Care, Inc. Peace River Center

Coastal Behavioral Healthcare, Inc. Personal Enrichment Through Mental

DACCO Behavioral Healthcare, Inc. Health Services (PEMHS)

David Lawrence Center Phoenix House

Directions for Living SalusCare, Inc.

First Step of Sarasota, Inc. Suncoast Center, Inc.

Gracepoint/Mental Health Care, Inc. Tri-County Human Services, Inc.

*Please initial*

 I authorize the release of this information only to these Network Service Providers:

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My signature authorizes CFBHN to disclose the information identified in this authorization to the Network Service Provider(s) specified above. Disclosures are limited to the minimum necessary to accomplish the purpose of this request. Disclosures will be made directly to identified parties, and in a secure manner by phone or email message.

I understand that my treatment, payment, enrollment and/or eligibility for benefits or Care Coordination services is not conditioned upon my signing this authorization.

I understand that the disclosures made as part of this authorization are confidential and protected by law. This information will not be disclosed by, or to, any other party without my express written consent or as permitted or required by law.

I understand that I have the right to revoke this authorization at any time by making the request, in writing, to my Care Coordinator. A request to revoke the authorization will be honored from that date forward, and cannot be applied to disclosures made previously when the release was in effect. If not revoked by me, this authorization will terminate on the expiration date documented on the form.

By my signature below, I acknowledge that I have given my consent freely, voluntarily and without coercion, and that I have been given a copy of this authorization, signed by me on the date shown below. I agree and understand that I may sign this form electronically by any means authorized by applicable law.

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Client SignatureDate

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Signature of client’s legal guardian or authorized representative, if applicable Date

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Printed Name of legal guardian or representative and relationship to client