IMPOWER
Inspiring Life's Potential

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

CLIENT NAME:_____ **DOB:**_____

This Authorizes:

IMPOWER

to release or obtain protected health information concerning the above named client including physical, mental health, substance abuse (ie. drug, alcohol), HIV/AIDS status information, diagnostic and treatment records. Health information may relate to my past, present or future condition, the provision of my health care, or payment for my health care services. This information may be disclosed to or obtained from the following:

Agency Name/Contact Person: **FLAGLER FREE CLINIC**
Mailing Address: **703 Moody Blvd**
City, State, Zip: **Bunnell, Florida 32110**
Phone: **386-437-3091**
Email: **terribelletto@cfl.rr.com**

I authorize: **Only** the following information is/are authorized for disclosure (check items to be released):

- ☐ Attendance record
- ☐ Results of urinalysis and frequency
- ☐ Biopsychosocial Evaluation
- ☐ Medication Management Visits
- ☐ Substance Abuse Evaluation
- ☐ Treatment Plan/Reviews
- ☐ Psychiatric Evaluation
- ☐ Progress reports/summaries
- ☐ Education Records
- ☐ Discharge Summary
- ☐ Referral for additional services, indicate agency referring to:_____
- ☐ Other: _____

Expiration:

This authorization expires:_____ **or** _____
Event(e.g. upon discharge, copying of records for referral) expiration date

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Purpose of Release: ☐ At the request of the individual ☐ Assessment ☐ Treatment Coordination ☐ Disability Determination ☐ Other - Please Specify:_____

Other Information:

- Information released by the above may not be redisclosed without further authorization. However, I understand that IMPOWER cannot guarantee that the Recipient will not re-disclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information.
- I understand that I may refuse to sign this Authorization and that my treatment, enrollment, eligibility for benefits, or payment of my treatment cannot be contingent on the signing of this Authorization.
- I understand that I may revoke this Authorization in writing at any time, however I cannot revoke authorization for action that has already been taken. This includes release to third-party payor. I further understand that I must provide any notice of revocation in writing to the Privacy Office at the address listed below.
- There is a cost of $1.00 per page for medical records.
- I shall receive a copy of this form after I sign it if the request for disclosure was initiated by IMPOWER
- **A copy of this release shall be valid as the original.**

THIS CONSENT EXPIRES 1 YEAR FROM THE DATE SIGNED UNLESS OTHERWISE SPECIFIED.

Client Signature:_____ Date:_____

Legal Guardian/Representative Signature:_____ Date:_____

Relationship to patient:_____