

**AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION**

**CHILD:**

 Last First Middle ID: DOB:

**PARENT**

**/LEGAL GUARDIAN:** Last First Middle Phone#

I have checked the boxes and provided my signature below for the agencies/providers for which I have given permission to [ ]  disclose and/or [ ]  obtain information for the purposes of improving the well being of my child named above via mail, phone, fax, video, or secure encrypted email. I understand the following:

* That information may be disclosed to parties listed below as required for billing and access to services and continuity of care.
* Only the minimum amount of information necessary to fulfill a request will be released/obtained.
* There may be a charge per page, plus postage and handling, for copy services unless copies are provided directly to an entity for the purposes of continuity of care.

[ ]  Children’s Medical Services Program(s) [ ]  Local Education Agency/School System

[ ]  Head Start/Early Head Start [ ]  Florida Diagnostic& Learning Resources System (FDLRS/child find)

[ ]  Office of Disability Determinations (SSI) [ ]  Department of Health Birth Defects Registry

[ ]  Children and Families Voluntary Family Services [ ]  Department of Health Newborn Screening Program

[ ]  Department of Education

[ ]  Medicaid/ Managed Care Plan

 Name Phone

[ ]  Private/Commercial Insurance

 Name Phone

[ ]  Pediatrician/Physician

 Name Phone

[ ]  Other

 Name Phone

[ ]  Hospital

 Name Phone

**INFORMATION TO BE DISCLOSED/OBTAINED: (check selection)**

[ ]  General Medical Record(s) [ ]  Progress Notes [ ]  History and Physical Results, including diagnostic information

[ ]  Immunizations [ ]  Consultations [ ]  Individualized Family Support Plan/Evaluation/Assessment Reports

[ ]  Other: (specify)

**I specifically authorize release of information relating to: (check selection if applicable)**

[ ]  HIV test results for non-treatment purposes [ ]  Substance Abuse Service Provider Client Records[ ]  Mental Health notes

**EXPIRATION DATE:** This authorization will expire (insert date or event) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

**RE-DISCLOSURE:** I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

**CONDITIONING:** I understand that completing this authorization form is voluntary. I realize that services will not be denied if I refuse to sign this form.

**REVOCATION:** I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to my service coordinator. I understand that the revocation will not apply to information that has already been released in response to this authorization.

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**PARENT/LEGAL GUARDIAN:**  Signature Date