

**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