AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

CLIENT NAME:_____ **DOB**:_____

This Authorizes: IMPOWER with offices located at:

587 E SR 434, Suite 1020 Longwood, FL 32750	1900 N. Central Ave. Kissimmee, FL 34741	1037 Pathfinder Way, Suite 130 Rockledge, FL 32955-3242

to release or obtain protected health information concerning the above named client. Health information may relate to my past, present or future physical or mental health 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: _____

Mailing Address:_____

City, State, Zip: _____

Phone: _____

Delivery method: ☐ Pick up ☐ Mail ☐ Phone ☐ Fax:_____ ☐ Email:_____

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

☐ Client Information Sheet ☐ Emotional and Behavioral Evaluation ☐ Psychosocial Evaluation
☐ Medication Management Visits ☐ Psychiatric Evaluation ☐ Individualized Treatment Plan
☐ Behavioral Program ☐ Progress Notes ☐ Treatment Plan Reviews
☐ Discharge Summary ☐ Progress Summary ☐ Other: _____

Expiration:

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

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

Other Information:

- 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 refusal to sign will not affect my ability to obtain treatment from IMPOWER.
- 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. I further understand that I must provide any notice of revocation in writing to the Privacy Office at the address listed above.
- There is a cost of $1.00 per page for medical records.
- **A copy of this release shall be valid as the original.**

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

Legal Guardian Signature:_____ Date:_____

Witness:_____ Date:_____