FlaglerCares

Helping People. Transforming Communities. Changing Lives.

Release of Information

I hereby authorize Flagler Cares to (please check one):

☐ Obtain ☐ Release ☐ Exchange

the following written, verbal, or electronic information concerning (please check all that apply):

☐ Treatment goals/progress
☐ Physical Exam
☐ Educational Information
☐ Alcohol/Drug Treatment
☐ Intake Completed
☐ Mental Health Treatment
☐ Other (Specify): _____

☐ Psychological Evaluation/test results
☐ Medical Treatment
☐ Social History
☐ Psychiatric Evaluation/Treatment
☐ Appt scheduled with Care Coordination

Client Information:

_____
First and Last Name

_____
Street Address

_____
City, State, Zip Code

_____
Date of Birth

_____
Email

Obtaining/Releasing Information to:

_____
Name (Organization or Individual)

_____
Street Address

_____
City, State, Zip Code

_____
Dates of Services

_____
Email

A signed revocation may be submitted at any time, but Flagler Cares shall not be held liable for any information released prior to its receipt. To the Receiving Agency: This information has been disclosed to you from records whose confidentiality is protected. Any further disclosure is strictly prohibited unless the client provides specific written consent for the subsequent disclosure of information. Authorization shall automatically expire one (1) year from the date client signed this authorization. *In compliance with Federal Regulations 42 CFR, Part 2 and with F.S. 90.503, 394.459(9), 395.3025(2)(3), 397.501(a).*

_____
Signature of Client (or legal guardian)

_____
Date

_____
Care Coordinator Witness Signature

_____
Date

Please Return Information to:

Attn: _____, Care Coordinator

Flagler Cares
160 Cypress Point Parkway
Suite B302
Palm Coast, FL 32164
Fax:
Email: