TAMPA BAY

PSYCHIATRIC SERVICES, PL

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize Tampa Bay Psychiatric Services, PL and its associates to

OBTAIN RECORDS ☐ RELEASE RECORDS ☐

and communicate, collaborate, consult and otherwise share my confidential medical/psychiatric/mental health information for the purpose of treatment planning and/or administrative functions with the doctor, hospital, insurance company or other entity listed below.

Patient's Name: _____
Address: _____
City/State/Zip _____
DOB:_____

Name of Doctor/Hospital/Institution/Individual:
_____
Dates of Services/Hospitalization: _____
Address: _____
City/State/Zip _____
Tel/Fax: _____

This consent is valid until: _____
(Date may not exceed one year from the date of signature)

I understand that I may revoke this consent at any time by giving written notice to Tampa Bay Psychiatric Services, PL and that I have the right to inspect and copy the information to be disclosed. It has been explained to me that if I refuse to consent to release the information, services may be delayed or denied.

Patient/Guardian Signature _____Date_____
(must sign if 12 years of age or older)

Signature of Responsible Party _____
(must sign if patient is under 18 years of age)

Relationship to patient _____

Witness Signature _____Date_____

NOTICE TO RECEIVING AGENCY OR PERSON:
Information disclosed to you from records whose confidentiality is protected by Federal or Florida laws and regulations may not be redisclosed by you without consent for redisclosure by the client and/or parent or legal guardian.