Southlake Autism and Behavior Services, PA
355 Citrus Tower Blvd, Suite 116
Clermont, FL 34711
Phone: 352.223.1999 ʘ Fax: 352.600.3119
www.southlakeautism.com

Authorization for Release of Information

Patients Name ______________________________

Patients Date of Birth ______________________________

Parents Name ______________________________

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of individually identifiable Health information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider the information may no longer be protected by the Federal privacy regulations.

I understand that my health information may contain information created by other persons or entities including health care providers, and may also contain drug and alcohol, mental health, HIV/AIDS, psychotherapy, genetic, reproductive and sexually transmitted disease information. I further understand that by signing this document, I am authorizing the release or exchange of this information with the person or organization named below.

I understand that my health plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by notifying SABS in writing. However, the revocation will not have an effect on any actions SABS took before it received the revocation.

I authorize Southlake Autism and Behavior Services to receive from or disclose mine or my family member's individually identifiable health information to the following person(s) or organization(s):

Name: ______________________________

Address: ______________________________

City, State, Zip ______________________________

Phone Number: ______________________________

Description of individually identifiable health information to be received or disclosed (check appropriate type(s) of information):

- ☐ All relevant information related to my healthcare services
- ☐ Treatment Plan(s)
- ☐ Claims
- ☐ Progress Reports
- ☐ Eligibility/Benefits EAP Participation
- ☐ information used to make benefit determinations
- ☐ Health Care Programs - Care Solutions, Behavioral Health, Disease Management
- ☐ Other (describe): ____

The purpose of this authorization is (check all that apply):

- ☐ To allow the appropriate management of treatment, services, and/or coverage under the member's benefit plan.
- ☐ Benefit Management
- ☐ Claims Administration/Payment
- ☐ Subpoena or other legal process
- ☐ Other (describe):

All dates of records will be disclosed unless you indicate differently below.

From________________(MM/DD/YY) To ________________(MM/DD/YY)

THE MEMBER OR MEMBER'S PARENT/REPRESENTATIVE MUST COMPLETE THE REST OF THIS FORM:

I understand that this authorization will expire:

On ________________ (MM/DD/YY) or one year from the date of the signature below.

________________________________ ________________________________
Signature of Individual's Parent/Representative Date

Patient's Parent/Representative(s)

Name: ____

Address: ____

City, State, Zip: ____

Phone Number: ____