

Southlake Autism and Behavior Services, PA

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Clermont, FL 34711

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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/YYYY) To _____ (MM/DD/YYYY)

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

I understand that this authorization will expire:

On _____ (MM/DD/YYYY) 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: _____