5104 North Orange Blossom Trail. Orlando Florida 32810. Phone: 407 394 7181. Fax 407 250 0788
Email. optimumhealthoutcomes@outlook.com

RELEASE OF CONFIDENTIAL INFORMATION FORM AUTHORIZATION

Name of Client: ____ D.O.B _______________________

I _________________________, the legal guardian and/or client of Optimum Health Outcomes, L.L.C hereby request and authorize for Optimum Health Outcomes, L.L.C to Release Exchange Obtain From by phone, fax or email.

Name of Organization:	
Organization Contact Information (Address, Phone, Fax, Email):	

To release confidential information consisting of *(indicate the specific information that may be released, i.e. Psychiatric, Drug / Alcohol Records or Information, Medical Records or Information; Social History; Psychological Records or Information, Educational or School Records, etc…)* ***Check below to indicate information desired.***

_☐Behavioral/Mental Health Evaluation
_☐In-Depth Assessments
_____ Psychiatric Evaluations
_____ Labs/Other Diagnostic Test
_____ Alcohol and Other Substance Use
_____ Psychological Evaluations
_____ Behavioral Issues
_____ Socialization Issues
_____ Other: ***BELOW LIST SPECIFICALLY WHAT ADDITIONAL INFORMATION IS DESIRED TO BE RELEASED:***

_____ School Attendance and Grades
_____ Educational/Learning Issues
_____ Face-to-Face Interviews
_____ Treatment Plans and Reviews
_____ Discharge Summary
_____ Recommendations
_____ Verbal Communications with:

Verbal Communication

Medication and Dosages	☐
Medical Conditions	☐
Significant Events	☐

Optimum Health Outcomes, L.L.C.	
Address:	5104 N. Orange Blossom Trial. STE 220 Orlando, FL 32810
Attention:	OHO Administration

I understand that only the above-specified information can be disclosed by the above-specified organization.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient [52 FR 21809, 1987; 52 FR 41997, Nov. 2, 1987]

This consent or authorization for release of information shall be effective the date of signature and shall expire at the time services are concluded. I also understand that I may revoke this consent or authorization at any time, providing I notify the program in writing to this effect. Revocation has no effect on action previously taken.

I/We understand that confidentiality cannot be assured when information is faxed, over the phone or emailed. My signature below signify acceptance of the risk that confidentiality may be breached when information is faxed, over the phone or emailed __

(Signature of Client or Parent/Guardian, if minor) ***(Date)***

(Signature of Witness) ***(Date)***

If the consumer has difficulty understanding or reading this document, please print the name of the person who read this document or explained it to the consumer:______________________________

CONSENT TO RELEASE Acknowledgement Form

CLICK HERE TO SUBMIT