

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 to: obtain from: exchange (please check) by phone, fax or email. I do not want information exchanged by:

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.**

- | | |
|---|---|
| <input type="checkbox"/> Behavioral/Mental Health Evaluation | <input type="checkbox"/> School Attendance and Grades |
| <input type="checkbox"/> In-Depth Assessments | <input type="checkbox"/> Educational/Learning Issues |
| <input type="checkbox"/> Psychiatric Evaluations | <input type="checkbox"/> Face-to-Face Interviews |
| <input type="checkbox"/> Labs/Other Diagnostic Test | <input type="checkbox"/> Treatment Plans and Reviews |
| <input type="checkbox"/> Alcohol and Other Substance Use | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Psychological Evaluations | <input type="checkbox"/> Recommendations |
| <input type="checkbox"/> Behavioral Issues | <input type="checkbox"/> Verbal Communications with: |
| <input type="checkbox"/> Socialization Issues | |
| <input type="checkbox"/> Other: BELOW LIST SPECIFICALLY WHAT ADDITIONAL INFORMATION IS DESIRED TO BE RELEASED: | |

<u>Medication and Dosages</u>	<input type="checkbox"/>
<u>Medical Conditions</u>	<input type="checkbox"/>
<u>Significant Events</u>	<input type="checkbox"/>

Optimum Health Outcomes, L.L.C.

Address:	5104 N. Orange Blossom Trail, 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: _____