Florida Psychiatry Associates, LLC (FPA)
260 NW Peacock Blvd., Suite 102, Port St. Lucie, FL 34986
Phone: (772) 878-7216 / Fax: (772) 878-7218
www.flpsychiatry.com

AUTHORIZATION TO DISCLOSE OR OBTAIN PROTECTED HEALTH INFORMATION (PHI)

I, the undersigned patient or legal representative, hereby authorize the use and disclosure of my health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV related information.

Patient Name:_____ **Date of Birth:**_____
(Print full name) (mm/dd/yyyy)

Complete this part for FPA to **DISCLOSE PHI**:	Complete this part for FPA to **OBTAIN PHI**:
I authorize Florida Psychiatry Associates to disclose my health information to: Name:_____ Address:_____ _____ Phone:_____ Fax:_____	I authorize _____ to disclose my health information to: Florida Psychiatry Associates, LLC 260 NW Peacock Blvd., Ste. 102 Port St. Lucie, FL 34986 Phone: 772-878-7216 Fax: 772-878-7218

Method of Disclosure: ☐ Mail ☐ Fax ☐ Verbal ☐ Pick up ☐ Email

Dates of service (if applicable):_____

Type(s) of information to be used or disclosed include:
☐ Psychiatric evaluation and follow up notes ☐ Psychiatric Intake and Evaluation ☐ Lab Reports/EKG
☐ Neuropsych Testing ☐ Urgent Care / ER Dept. Records ☐ Discharge Summary ☐ Complete Record

* **The parent or legal guardian must sign the authorization if the patient is a minor (under age 18) or has a legal guardian.**
* This authorization will be valid for a period of one year from the date below. I understand that I may revoke this authorization at any time by notifying Florida Psychiatry Associates LLC in writing.
* I understand the revocation will not apply to information that has already been released in response to this authorization.
* I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.
* I understand that my treatment or continued therapy by Florida Psychiatry Associates is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.
* Minors receiving drug abuse treatment may sign their own authorization.

PROHIBITION ON RE-DISCLOSURE: This information has been disclosed from records whose confidentiality is protected. Federal and state rules prohibit anyone from making any further disclosure of this information unless the patient provides specific written authorization for the subsequent disclosure of this information or as to otherwise permitted by 42.C.F.R. Part 2 or F.S.A. §394.4615. Florida law requires that any person, agency or entity receiving this information shall maintain such information as confidential and exempt from the provisions of the public law (F.S.A. §394.4615(6). Any facility or private mental health practitioner who acts in good faith in releasing information pursuant to F.S.A. §394.4615 or other Florida statute is not subject to civil or criminal liability for such release.

Name of Patient _____ **Name of legal guardian (*If Patient is a minor*)** _____

_____ **Date** _____
Signature of Patient, Legal Guardian