AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I understand that Florida law requires each client's consent for the release of confidential information related to mental health or developmental disability. With this understanding, I hereby waive any right to confidentiality arising under Florida law and authorize release of records of information, but only to the extent specified below.

I, ____ (client/guardian), authorize **Metamorphosis Psyche, LLC** to disclose/exchange mental health information and records obtained during the course of psychiatric treatment including, but not limited to, the psychiatric provider's diagnosis (es).

Provide the person and/or organization's name and address:

Name/Organization: ____

Phone: ____ **Fax**: ________________________________

Address:____

City/State/Zip:____

I authorize **Metamorphosis Psyche, LLC** to release and/or receive the following information concerning myself or my child:

- o Policy/Procedures
- o Patient Registration
- o Intake Screening
- o Screening Tools
- o Diagnosis (es)
- o Psychiatric Evaluation (s)
- o F/U Psychiatric Evaluation (s)
- o Treatment Summary
- o Medical History
- o Hospital Records
- o Discharge Summaries
- o Dates of Treatment Service
- o Academic Records
- o Other (specify) __________________________________ __________________________________ ______
- o Verbal Communication

6101 West Atlantic Blvd., Ste 202, Margate, FL 33063
Tel: 954.906.4106 | Fax: # 954.906.4029

I wish for disclosures to limit specific information noted below:
____
____
____

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations for the purpose of:

- o Evaluation/assessment and/or coordinating treatment efforts
- o Other (specify) ____

This consent will automatically expire one (1) year after date of my signature as it appears below, or on the following earlier date, condition, or event

Rediscolsure:

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State Law applies that is stricter than HIPAA and provides additional privacy protections.

I understand that I have the right to refuse to sign this form, and that I may revoke my consent at any time by notifying **Metamorphosis Psyche, LLC** in writing **(except to the extent that the information has already been released)**.

_____ **Check here if client/guardian refuses to sign authorization**

_______________________________________ _______________
Client/Legal Guardian Signature Date

_______________________________________ _______________
Client/Legal Guardian Printed Name Date

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