Vital Minds Psychiatry, LLC.

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

FOR THE RECIPIENT:
If any of the requested records contain information regarding alcohol or drug abuse treatment, it is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit disclosure of health information unless expressly permitted in writing by the client to whom it pertains or as otherwise permitted by 42 CFR Part 2. Federal rules restrict use of this information to criminally investigate or prosecute a client for alcohol or drug abuse.

I understand that my records are protected under the Federal Regulations governing confidentiality of Alcohol and Drug Abuse patient records, and this notice accompanies a disclosure of such information.

I hereby authorize: _____ to release my health information and records obtained during my treatment:

Patient Name: _____ Phone: _____

Address:_____

Date of Birth: _____ Last Four Digits of SSN: _____

The information is to be released to:

Vital Minds Psychiatry, LLC.
5840 Red Bug Lake Rd #1602,
Winter Springs,
FL 32708
Fax: (407) 633-7556

I understand that this authorization extends to all, or any part of the records designated below which may include treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS test results or diagnoses:

__ History and Physical
__ Diagnostic Assessment
__ Individual Service Plan
__ Treatment Progress
__ Psychiatric Evaluation
__ Prescription Records
__ Discharge Summary
__ Entire Individual Client Record
__ Other_____

The purpose or Need for Disclosure is:

__ Medical treatment __ Disability __ For follow up care __ Other_____

1. I understand that unless I revoke this authorization, it will expire in 180 days or according to relevant state law.
2. **Re-disclosure:** I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law and could be used or re-disclosed by the receiving party.
3. **Refusal to sign:** I understand that I may refuse to sign and that Vital Minds Psychiatry, LLC. will not condition treatment on signing this authorization.
4. **Certification:** I certify that I am (check whichever applies):
   - ❑ The client, and the identification that I have provided is true and correct.
   - ❑ The client's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of: _____.
5. **Copy:** I understand that I will receive a copy of this completed form.
6. I understand that the information, whether in digital form or in a paper medical record, will remain confidential in compliance with HIPAA rules and regulations.

_____ _____
Signature of patient /Legal Guardian **Date**