Hancock-Smith
Pediatric & Behavioral Health, LLC
Wellness. Empowerment. Change.
15260 NW 147th Drive, Suite 200, Alachua, FL 32615

RELEASE OF INFORMATION CONSENT

Patient's name:

* **I authorize Hancock-Smith Pediatric & Behavioral Health, LLC to**:
Send
Receive

The following information:
Medical history and evaluation(s)
Mental health evaluations
Developmental and/or social history
Educational records
Progress notes, and treatment or closing summary
Other

* **To / From (e.g. school, pediatrician, occupational therapist)**:

Phone:

* **Your relationship to patient**:
Self
Parent/legal guardian
Personal representative
Other

* **The above information will be used for the following purposes**:
Planning appropriate treatment or program
Continuing appropriate treatment or program
Determining eligibility for benefits or program
Case review

Updating files

Other

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

* **Signature**:

* **Date**:

Witness signature (if patient is unable to sign):

Witness Date: