



The Costello Center
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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Client Name (Please Print): _____ Date: _____

I, (print name) _____, hereby authorize
_____ to receive and/or release the following protected
health information (PHI) to or from the individual or organization identified below:

All records

Specific Information:

Individual or Organization:

Name/ Organization: _____

Relationship to client: _____

Address: _____

Phone: _____

Fax: _____

E-mail: _____

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Client information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d *et seq.* 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2 Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. 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 any Alcohol or Drug abuse patient. (42 C.F.R. 2.32)