The Costello Center
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Saint Petersburg, FL 33710
Phone: (727) 345-2667 Fax: (727) 209-2667
www.thecostellocenter.com

Authorization to Use or Disclose Protected Health Information

Client Name: _____ Date of Birth: _____
(Please Print)

The Costello Center Provider(s): _____
(Please Print)

*** The Costello Center includes Independent Consultants who are neither employees nor staff of the center but are Independent Providers whose offices are held at The Costello Center.**

I authorize The Costello Center to make disclosure to the individual or organization identified below:
☐ RELEASE TO ☐ RECEIVE FROM ☐ EXCHANGE WITH

I acknowledge and hereby consent to release information from my health record including mental, psychiatric, alcohol and/or drug abuse, eating disorders or any other medical information of a sensitive nature to the following individuals or organization(s):

Name: _____ *Relationship:* _____

Phone: _____ *Fax:* _____

Email: _____ *Client's consent to email must be on file

Address: _____
(City) *(State)* *(Zip)*

The information that I am authorizing for disclosure will be used for the following purpose:
☐ Continuity of Healthcare Treatment ☐ Education ☐ Insurance/Disability ☐ Legal Reasons ☐ Personal

The type of information to be disclosed is as follows: (check all of the appropriate boxes)

☐ Diagnosis
☐ Progress Notes/Treatment Summary
☐ Intake Paperwork/History
☐ Psychiatric Evaluation
☐ Medication Information
☐ Dates of Treatments
☐ Billing Information
☐ Other (Specify): _____

I understand that if the organization authorized to receive the information is not a healthcare provider; the release information may no longer be protected by federal privacy regulations. I understand that I need not sign this authorization to ensure treatment. This authorization shall remain valid for one year from the date signed below.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to The Costello Center. I understand that the revocation will not apply to information that has already been released in response to the authorization.

Signature: _____ Date: _____

☐ **Client** *or* **Authorized Person**: ☐ Parent ☐ Legal Guardian ☐ Power of Attorney

Witness: _____ Date: _____

* The Costello Center reserves the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

*This authorization form may not be used for the re-release of confidential information provided to The Costello Center by other individuals or organization(s). Such requests should be referred to the original individual or organization(s).

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)