Authorization for Exchange of Information between Multiple Providers

Policies and Procedures

Policy

This Authorization form permits individuals to use a single form for the release of general medical, mental health, substance abuse, and/or legal information to multiple providers, and allows those providers to share specified information among and between them.

Purpose

This form is intended to reduce paperwork and facilitate sharing of information that is essential to delivering quality care between multiple providers and/or community service systems and organizations that are or have been involved in an individual's care.

Procedures

When multiple providers and/or service systems have been or are significantly involved in providing services to an individual, or when referrals are being made to multiple providers and/or service systems, this release form may be used in lieu of separate forms for each provider or agency. Providers will review the authorization form with the individual and/or parent/guardian to ensure that the purpose and scope of the release is understood and that persons served are aware that use of this authorization form is strictly voluntary.

All entities listed on one authorization form have the same access to information, though in all cases disclosures should be limited to the minimum information necessary to accomplish the purposes of the authorization. In those cases where the person prefers to that different providers have different levels of access to information, individual release forms should be signed.

The release must be completed fully, including the names and addresses of the organizations or agencies that are being authorized to release and receive information; the types of information permitted to be shared; the purpose of disclosure; the date range of services covered by this authorization; the expiration date of the consent; and the signature of the client and/or parent/guardian and date of signature. If new or additional providers are identified after this release is signed, a new authorization to include them will be necessary. Additional agencies or providers may not be added to an existing form after the date of signature. Faxed or photocopied versions of this release form are also acceptable

AUTHORIZATION AND CONSENT FOR DISCLOSURE, RECEIPT AND USE OF CONFIDENTIAL INFORMATION BY MULTIPLE PARTIES FOR ALCOHOL, SUBSTANCE ABUSE AND/OR MENTAL HEALTH PATIENTS

CONSUMER NAME: _____
CONSUMER SSN:_____ CONSUMER DOB:_____

NAME OF SERVICE PROVIDER: _____

I _____
[*print consumer name]*

hereby authorize any of the parties designated below to communicate with one another through disclosure, receipt and use of my confidential information for purposes of evaluating my need, coordinating and/or providing services to me. Any disclosure, receipt or use of information by the parties will be limited to the minimum that is reasonably necessary to accomplish the intended purpose.

AUTHORIZED PARTIES

[CONSUMER INITIAL EACH THAT APPLIES]

ALCOHOL, SUBSTANCE ABUSE AND MENTAL HEALTH PROVIDERS:

_____MENTAL HEALTH CARE (MHC)
_____NORTHSIDE MENTAL HEALTH CENTER
_____AGENCY FOR COMMUNITY TREATMENT SERVICES (ACTS)
_____GULFCOAST JEWISH FAMILY SERVICES
_____BOLEY CENTERS
_____DACCO
_____PHOENIX HOUSE
_____CENTER FOR WOMEN
_____SALVATION ARMY
_____GOODWILL
_____TAMPA CROSSROADS
_____OTHER (*specify*:)_____

GENERAL HEALTH CARE PROVIDERS (including but not limited to alcohol, substance abuse and / or mental health treatment services):

_____TAMPA GENERAL HOSPITAL
_____ST. JOSEPH'S HOSPITAL
_____MEMORIAL HOSPITAL
_____HEALTH MANAGEMENT ORGANIZATION (*specify*:)_____
_____OTHER HEALTH CARE PROVIDERS (*specify*:)_____

OTHER SERVICE PROVIDERS:

_____HILLSBOROUGH KIDS (HKI)
_____FLORIDA DEPARTMENT OF JUVENILE JUSTICE (DJJ)
_____HILLSBOROUGH COUNTY PUBLIC SCHOOLS
_____OTHER PROVIDERS (*specify*:)_____

ADMINISTRATIVE SERVICE ORGANIZATIONS:

_____FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
_____CENTRAL FLORIDA BEHAVIORAL HEALTH NETWORK
_____ QUALIFIED SERVICE ORGANIZATIONS
_____OTHER (*specify*:)_____

FINANCIAL ASSISTANCE AND RESOURCE OFFICES:

_____SOCIAL SECURITY ADMINISTRATION (SSA)
_____MEDICAID (DCF)
_____FOOD STAMPS (DCF)
_____WOMEN, INFANTS AND CHILDREN (DCF)
_____TEMPORARY AID FOR NEEDY FAMILIES (DCF)

OTHER CONSUMER DESIGNEES: *(specify)*:_____

The nature and amount of information that may be disclosed, received and/or used by the parties pursuant to this authorization is as follows:

[CONSUMER INITIAL EACH THAT APPLIES]

_____My name and other personal identifying information.
_____My identity as an applicant for, or recipient of alcohol, substance abuse and/or mental health treatment services.
_____Initial and subsequent evaluations and assessments of my service needs by the following:

_____Summaries of alcohol, substance abuse and/or mental health assessments and history;
_____Summaries of alcohol, substance abuse and/or mental health service plan(s);
_____ Attendance, progress and compliance in alcohol, substance abuse and/or mental health services;
_____ Discharge plan(s) for alcohol, substance abuse and/or mental health services;
_____ Date and status of discharge from alcohol, substance abuse or mental health services;
_____ Psychiatric testing information and diagnosis;
_____ Psychosocial history;
_____ Other *[specify]*_____.

The purpose for disclosure, receipt and use of information authorized by me in this document is to enable the parties to evaluate my need, coordinate and provide services to me.

I understand that generally, my treatment, payment, enrollment or eligibility for benefits may not be conditioned upon my signing this authorization, but that in certain limited circumstances, I may be denied treatment if I do not sign an authorization.

I understand that the confidentiality of any information disclosed, received or used pursuant to this authorization is protected by law and will not be further disclosed by, or to any other party without my express written consent, or as otherwise permitted or required by applicable law.

I further understand that I have the right to revoke this authorization in writing at any time, except to the extent that any authorized party has already taken action in reliance on it If not previously revoked by me, this authorization will terminate as of the following date, event or condition, not to exceed one (1) year from the effective date hereof.

_____

[*specify date, event or condition of termination*]

By my signature below, I acknowledge that I have given my consent as indicated above freely, voluntarily and without coercion, and that I have been given a copy of this authorization, signed by me on the date shown below.

_____ _____

[signature of consumer or consumer's authorized representative] *[effective date]*

_____

Description of authority if signed by consumer's authorized representative