

Lee Mental Health Center, Inc.
2789 Ortiz Avenue * Fort Myers, Florida 33905

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

CLIENT NAME _____ DATE OF BIRTH _____

AUTHORIZATION FOR (check as appropriate): REQUEST FOR INFORMATION RELEASE OF INFORMATION

I authorize Lee Mental Health Center to request/release information and/or records of the individual named above.

I understand that my clinical record may include information relating to HIV/AIDS, behavioral or mental health services, and/or substance abuse services (42 CFR).

This information may be released to/requested from the following:

(1) Facility/Person _____
Address _____
The information and records are for the purpose
of _____
Information to be released includes (check one):
 all information
 specific information/reports, such
as _____

I understand that I have a right to cancel this authorization at any time by presenting my written cancellation to the Clinical Records Department. I understand that the cancellation will not apply to information that has already been released in response to this authorization. I understand that the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I do not cancel this authorization, it automatically expires as follows:

PLEASE INITIAL ONE CHOICE:

- Six months after the date on which my treatment is completed
 On ____/____/____
 One time only for current records/information

I understand that authorizing the disclosure of this information is voluntary. I do not need to sign this form in order to receive treatment. I understand that the above information may be disclosed by the recipient of the information. Most health care providers and insurance plans must follow federal rules protecting the privacy of health information. However, Lee Mental Health Center cannot guarantee that others receiving the information will protect it.

Client or Legal Representative Signature Date

If Signed by Legal Representative, Describe Relationship to Client Witness Signature

CLIENT NAME:	CASE #:
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