JFS Orlando
www.jfsorlando.org

The George Wolly Center
2100 Lee Road · Winter Park, FL 32789
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AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION

_____
Client Name Date of Birth

_____
Address Phone Number

I hereby authorize JFS Orlando, LLC. To release records to: ____ or obtain records from: _____

_____
Name of Facility or Person Phone Number Fax Number

_____
Address City State Zip

Send Records To:

_____
Name of Facility or Person Phone Number Fax Number

_____
Address City State Zip

I understand the purpose for allowing the release of information is:

___ To complete an assessment of and determination of my needs
___ To best provide for receiving the most appropriate services
___ Insurance
___ Legal Action
___ Continued Treatment
___ Communication
___ Other: _____

I understand that this consent is revocable upon written notice to the Agency except to the extent that the action by the agency has been taken in reliance of this authorization and this authorization shall remain enforceable for a reasonable time in order to affect the purpose for which it is given. Alcohol and drug abuse information, if present, has been disclosed from records which confidentiality is protected by Federal law. Federal regulations (42CFR, Part II) prohibits making any further disclosures without the specific written authorization of the undersigned, or as other permitted by such regulations.

By signing, I am stating that I am aware that utilizing my mental health records for legal purposes is left up to the interpretation by legal representatives and may or may not be beneficial to my legal case. I hereby release JFS Orlando, Inc. from any and all claims or liabilities resulting from the lease of the above matters in accordance with this counsel.

This expires on _____, 20____

_____ _____ _____ _____
Client or Legal Guardian Signature Date Agency Representative Signature Date