Better Living Solutions Recovery Center

820 E Park Ave
Building I Suite 100
Tallahassee FL 32301
850-765-6769

0. Consent to Release Confidential Information to an Additional Person/Organization (If Applicable)

Better Living Solutions Recovery Center, LLC * Phone 850-765-6769 * Fax (850) 270-6932

Client's Name::

Client's Date of Birth::

Guardian of Client (if adolescent)::

I hereby consent and authorize Better Living Solutions Recovery Center to obtain medical records from and/or release records to the person/organization specified below.

Name of Person:

Address, city, state, zip code, & phone number:

Information That May Be Disclosed (check all that apply)

- [ ] All Items Below / Complete Medical Record
- [ ] Appointment Information (Place/Date/Time)
- [ ] Admissions profile
- [ ] Diagnosis, brief description of progress/prognosis
- [ ] Multidisciplinary discharge summary/aftercare plan
- [ ] Initial Assessment and Intake
- [ ] Multidisciplinary treatment plan
- [ ] Multidisciplinary treatment team progress notes
- [ ] Financial Information necessary for the processing and payment of program/facility billing
- [ ] School records or work related documents

☐ Verbal collaboration amongst providers

Other::

Information May Be Shared For The Following Reasons Unless Specified Below:

1) Support from a friend or family member during the treatment process.

2) Collaboration of care amongst current treatment team or referrals to additional health care providers

3) Billing of services rendered

4) To obtain benefits or address issues related to employment, education and/or government benefits.

Other ::

I am aware the duration of this authorization Is valid until one year from date of discharge or resolution of billing for services unless specified otherwise here:

Other specified reason::

I understand I may revoke this consent at any time by notifying the facility in writing, except to the extent that action has been taken in reliance on my consent. A photocopy of this authorization is to be considered as valid as the original document.

Notice to recipient of information: This information has been disclosed to you from records protected by Federal confidentiality rules [42 CFR Part 2]. The 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 DFR Part 2. A general authorization for this release of medical or other information is not sufficient for this purpose. This information is also protected by Florida State Statute. As per Florida State Statute, this information shall be held confidential and may not be further disclosed without the informed consent of the person to whom it pertains.

Please type your name below, as your electronic signature, to confirm the above statement::

Date of Electronic Signature::