SARASOTA COUNTY DUI/DRUG COURT, ENHANCED DRUG COURT AND MENTAL HEALTH COURT
1991 Main Street, Suite 180
Sarasota, FL. 34236
Ph: 941-861-8120 Fax: 941-316-1637

AUTHORIZATION TO RELEASE / OR RECEIVE INFORMATION
(In accordance with Federal Law, 42 C.F.R. Part 2)

CLIENT NAME:_____ DATE:_____

D.O.B.:_____ S.S.N.:_____

This form will authorize **Sarasota County DUI/Drug Court or Mental Health Court** to release / or receive general medical alcohol/ drug abuse, psychiatric / psychological information from my record in accordance with Florida Statutes and Florida and Federal Administrative Rules and Regulations to / from: (Please write name of the person or agency you would like information released to or from and address with zip code if information is to be mailed.)

____ Manatee Glens
____ Sarasota County Health Department
____ Department of Children and Families
____ Doctors Hospital of Sarasota
____ First Step of Sarasota
____ Treatment Court ARNP
____ Manatee County Sherriff's Office
____ Sarasota Memorial Hospital
____ Sarasota County Police Department
____ Sarasota County Sherriff's Office
____ Other: _____

(Initial all that apply below)

Information to be: _____ Released _____ Received as follows:

_____ Discharge Summary
_____ Program Participation
_____ Physical / Nursing Assessment
_____ Psychiatric / Psychosocial Assessment
____ Drug Screens
____ Treatment Plan / Reviews
____ Admission / Financial Status
____ Other_____

Purpose(s) of Disclosure:_____

Type of Communication Authorized: (*Initial all that apply*)

_____Fax _____Verbal _____Written This is a Single Disclosure YES / NO

PROHIBITION OF RE-DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further re-disclosure is strictly prohibited unless the client provides specific written authorization to you for the subsequent disclosure of this information.

I hereby release Sarasota County DUI/Drug Court or Mental Health Court from any liability which may arise as a result of the use of the information contained in the records released.

I understand that I have the right to refuse this authorization. If this authorization is needed to release information to an entity that has compelled my treatment, and I refuse to sign the authorization, Sarasota County DUI/Drug Court, or Mental Health Court may refuse to provide the treatment.

This consent is subject to revocation at any time except to the extent that the agency which is to make the disclosure has already taken action in reliance on it. I may revoke this consent by providing Sarasota County DUI/Drug Court or Mental Health Court notification in writing of my wish to revoke the authorization. If not previously revoked, this authorization will terminate upon; (State Date, Condition or Event upon which this authorization will terminate. This should be completed.)_____; or within one year from date of signature if no entry made.

SIGNATURE OF CLIENT _____ DATE_____

REPRESENTATIVE OF CLIENT: _____ DATE _____

(Description of representative's Authority) _____