HALIFAX BEHAVIORAL SERVICES
HALIFAX HEALTH MEDICAL CENTER
CHILDREN & ADOLESCENT PSYCHIATRIC SERVICES
841 Jimmy Ann Dr., Daytona Beach, FL 32117
ADULT PSYCHIATRIC SERVICES
303 N. Clyde Morris Blvd., Daytona Beach, FL 32114
ADULT OUTPATIENT PSYCHIATRIC SERVICES
303 N. Clyde Morris Blvd., 201 Bldg., Suite 230, Daytona Beach, FL 32117

Patient Name _____
Physician _____
Date of Birth_____ Gender_____
Med. Record # _____

AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____

Date of Birth: _____ SSN: _____

I voluntarily authorize Halifax Behavioral Services to release/obtain written and /or verbal information from the following agencies:

(Initial all that applies)

____ Department of Children & Families
____ Community Partnership for Children
____ Department of Juvenile Justice
____ Flagler County Schools
____ Volusia County Schools
____ SMA Behavioral
____ Lutheran Services of Florida

____ A Helping Hand
____ ADAPT Behavioral
____ Children Home Society
____ Chrysalis Health
____ Devereux of Florida
____ Division of Blind Services
____ Florida Dept. of Law Enforcement
____ House Next Door

____ Housing Authority
____ Medallion Healthcare
____ Neighbor to Family
____ SAAFE
____ Strategies, Inc.
____ Social Security Administration
____ Other _____
____ Other _____
____ Other _____

The information to be released/obtained is to be used for the purpose of or may include:

Admission & Discharge Summary
Benefits Determination
Care Coordination
Continuity of Care
Criminal Involvement
Follow up Care
Housing & Placement
Master Treatment Plan
Physical Examination
Psychological Reports
Safety Plan
School Records

I understand these records may include confidential psychiatric, psychological, drug, alcohol, HIV, and/or medical information.

Although treatment in this hospital is not contingent upon this consent, I understand that my refusal to consent will prevent disclosure of the information as specified above.
The consequences of my refusal, if known, are:_____
_____
_____

This authorization expires 180 days from the date of signature or from the date of discharge, whichever is later, unless otherwise revoked by me **in writing** prior to that time. Halifax Behavioral Services is not to be held liable for any release of information made prior to receiving such notification.

_____ _____
SIGNATURE OF PATIENT SIGNATURE OF WITNESS

_____ _____
DATE TIME DATE TIME

_____ _____
SIGNATURE OF PARENT/GUARDIAN SIGNATURE OF WITNESS

_____ _____
DATE TIME DATE TIME

HBS/PSYCH CON

REDISCLOSURE: Persons, agencies, or institutions to whom this information is disclosed are prohibited by state/federal law from redisclosure without the specific written consent of the person to whom it pertains. A general authorization for release of medical information is NOT sufficient for this purpose.