Community Health Centers of Sarasota County

Florida Department of Health

Multiagency Consent Form

AUTHORIZATION AND CONSENT FOR DISCLOSURE, RECEIPT AND USE OF CONFIDENTIAL INFORMATION BY MULTIPLE PARTIES FOR MENTAL HEALTH, ALCOHOL, AND/OR SUBSTANCE ABUSE PATIENTS.

CLIENT NAME: _____

CLIENT SSN: _____ CLIENT DOB: _____

NAME OF SERVICE PROVIDER:

I hereby authorize any of the parties designated below to communicate with one another through disclosure, receipt and use of my confidential information for purposes of evaluating my need, coordinating and/or providing services to me. Any disclosure, receipt or use of information by the parties will be limited to the minimum that is reasonably necessary to accomplish the intended purpose.

AUTHORIZED PARTIES (CLIENT INITIALS ALL THAT APPLY)

WRITTEN CONSENT _____

VERBAL CONSENT _____

MENTAL HEALTH, ALCOHOL, AND/OR SUBSTANCE ABUSE PROVIDERS:

_____Palm Shores Behavioral Health Center
_____Charlotte Behavioral Health Center
_____Coastal Behavioral Healthcare, Inc.
_____First Step of Sarasota, Inc.
_____Goodwill
_____Jewish Family & Children's Service of Suncoast
_____Mental Health Community Centers
_____The Charis Center
_____Family Preservation Services
_____Renaissance Manor
_____ Salvation Army
_____Bayfront Punta Gorda (Riverside)
_____Suncoast Behavioral Health Center
_____Manatee Glens
_____NAMI
_____Cornerstone Psychiatric Services
_____Other (Specify) _____
_____Other (Specify) _____
_____Other (Specify) _____

FINANCIAL ASSISTANCE AND RESOURCE OFFICES:

_____Social Security Administration (SSA)
_____Medicaid (AHCA)
_____Food Stamps (DCF)
_____Women, Infants and Children (WIC)
_____Temporary Assistance for Needy Families (DCF)
_____Other (specify): _____

OTHER SERVICE PROVIDERS: _____

The nature and amount of information that may be disclosed, received and/or used by the parties pursuant to this authorization is as follows: (Client initials all that apply)

_____My name and other personal identifying information
_____My identity as an applicant for, or recipient of substance abuse and/or mental health treatment services.
_____Initial and subsequent evaluations and assessments of my services needs by the following:
- _____Summaries of primary healthcare assessments and history including laboratory and medications
- _____Summaries of mental health and/or substance abuse assessments and history
- _____Summaries of mental health, alcohol, and/or substance abuse service plan(s)
- _____Progress and compliance in substance abuse and mental health services
- _____Discharge plan(s) for mental health, alcohol, and substance abuse services
- _____Date and status of discharge from mental health or substance abuse services
- _____Psychiatric testing information and diagnosis
- _____Psychosocial history
- _____Other (*specify*): _____

The purpose for disclosure, receipt and use of information authorized by me in this document is to enable the parties to evaluate my need, coordinate and provide services to me.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned upon my signing this authorization for release of my information. I further understand that I may be required to sign an informed consent for treatment, or other authorizations, in some circumstances, in order to receive treatment or benefits. This release not only covers the provision and receipt of all records maintained by _____, but also authorizes any member of the staff, employee of, or entity contracting with _____ to discuss the case, treatment, and records with the persons authorized to receive information either in private conversations, depositions, or court testimony.

NOTICE TO RECEIPIENTS OF INFORMATION: Any information disclosed to you was taken from the records of which the confidentiality is protected by State (394.459, 397.053, 381.609), (455 and 90) and/or Federal Law (42CFR, Part 2) (45 CFR 160-164). Federal Regulations (42CFR, Part 2) (45 CFR 160-164), prohibits disclosure by provider without my written consent unless otherwise provided for in the regulations.

I further understand that I have the right to revoke this authorization in writing at any time, except to the extent that any authorized party has already taken action in reliance on it. If not previously revoked by me, this authorization expires twelve (12) months from the time it is signed. _____ (specify date, event or condition of termination).

By my signature below, I acknowledge that I have given my consent as indicated above freely, voluntarily and without coercion, and that I have been given a copy of this authorization, signed by me on the date shown below.

_____ _____
Signature of consumer Effective date

_____ _____
Consumer's legal guardian or authorized representative Effective date

_____
Description of authority if signed by consumer's authorized representative