BayBrooke Center

for Independence & Wellness

Authorization for Release of Information

The undersigned hereby authorizes BayBrooke Center to receive or release the below listed information to or from the following named agency or physician:

BayBrooke Center
4995 49th St N
St. Petersburg, FL 33709

AND ______________________________
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____
____

INFORMATION:

___ Medical
___ Educational
___ Social History
___ Any and all information regarding treatment
___ Intellectual
___ Psychological Evaluation
___ Psychiatric Evaluation

PATIENT:

Name: ______________________________ Birth Date: ______________
Address: ____
City: ____________________ State: __________ Zip Code: ______________

The undersigned authorized the release of information for the following purpose:

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I understand that the information released by other professional to BayBrooke Center will be protected as private data according to the provisions of state and federal laws and, to the extent permitted by law, will not be released without my authorization. This does not mean that these materials will be protected from subpoena power.

I recognize that BayBrooke Center cannot guarantee the privacy of information released, but it is my intent that the party I designate to receive it will consider it private according to the provisions of state and federal laws. Further, I understand that I may rescind this authorization at any time by giving written notification to the above-named parties and otherwise it will expire one year from this date.

My authorization is given freely and with competence and adequate understanding of purpose.

______________________________ ______________________________
Patient's Signature Witness

______________________________ ______________________________
Legal Guardian, if minor Date