



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 Street N

St. Petersburg, FL 33709

FAX: 727.279.4631 OFFICE: 727.827.7890

INFO@BAYBROOKECENTER.COM

AND _____

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:

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