RELEASE OF INFORMATION

THIS FORM MUST BE ENTERED INTO THE ELECTRONIC HEALTH RECORDS

DATE: _____

Client Name: _____

Address: _____ **Date of Birth:** _____

I authorize Aspire Health Partners to:

☐ Release information to the person/organization below

☐ Obtain information from the person/organization below

Name: _____ **Relationship:** _____

Address: _____

Phone:_____ **Fax**:_____

Email:_____

For the purposes of:

☐Continuity of care
☐Determine need/eligibility for additional services
☐Confirm my status in the program
☐Legal
☐At my request
☐ Other: _____

Information to be released:

☐ Entire Medical Record, including psychiatric/mental health records, substance use disorder records, and HIV/AIDS-related information (excluding psychotherapy notes). ***By selecting "Entire Medical Record," I understand that the disclosure may include psychiatric/mental health records, substance use disorder records, and HIV/AIDS-related information unless otherwise limited below.***

Or

☐ Only the following:

☐ Assessments/Evaluations ☐ Treatment Plans ☐ Medication Records ☐ Laboratory Results ☐ Discharge Summaries

☐ Attendance Records ☐ Psychiatric/Mental Health Records ☐ Substance Use Disorder Records ☐ HIV/AIDS-Related Information

☐ Other: _____

I authorize the following forms in which the information should be released:

☐Verbal Communication ☐Written Records ☐Faxed ☐ Secure Electronic Transmission

Chose only one option:

☐ Release records created on or before the date signed.
☐ Release records created through the expiration date listed below.

I understand that this authorization may be revoked at any time by providing written notice to Aspire Health Partners, except to the extent that action has already been taken in reliance upon this authorization. If not previously revoked, this authorization will expire on the date or event specified below.
Expiration Date or Event **(not to exceed 12 months.)**:_____
Psychiatric, substance use disorder, and HIV/AIDS-related information disclosed from records protected by state and federal law (including Chapters 381, 394, and 397, Florida Statutes; 42 CFR Part 2; and 45 CFR Parts 160 and 164) may be subject to redisclosure by the recipient and may no longer be protected by applicable privacy laws. Further disclosure of information received by Aspire Health Partners will not occur without the individual's written authorization, unless otherwise permitted or required by law.
Signing this authorization is voluntary. Aspire Health Partners does not condition treatment, payment, enrollment, or eligibility for benefits on whether an individual authorizes the release of the information described above.
If you have executed a consent for Aspire Health Partners to release confidential information in connection with a criminal justice system referral, that consent may supersede this authorization as permitted by applicable law and policy.
Note to Requesting Party: Florida law establishes guidelines regarding fees that may be charged for copying records. Your signature acknowledges your understanding of this statement.

_____ _____
CLIENT SIGNATURE DATE OF SIGNATURE

If signed by a representative: _____ _____
SIGNATURE OF REPRESENTATIVE (please include signing authority: Parent, Guardian, POA, etc.) DATE OF SIGNATURE

_____ ***AT*** _____ ◉ ***AM*** ○ ***PM***
(DATE) ***(TIME)***

* ***REVOCATION OF RELEASE AUTHORIZED BY CLIENT IN WRITING ON***

Once completed, please return this form and any supporting identification directly to:

Aspire Health Partners
Medical Records / Release of Information Department
Mail: 1800 Mercy Drive, Orlando, FL 32810
Phone: (407) 875-3700 ext. 6762
Fax: (407) 667-1677
Email: ReleaseOfInformationRequests@aspirehp.org

****Please submit records and requests directly to the Medical Records/ROI Department to avoid processing delays. ****