DISC VILLAGE

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Please provide the following Protected Health Information on:

Name of Person: _____

Date of Authorization: _____

Personal Identifying Information:

Date of Birth: _____ **SSN:** _____ **MIS #:** _____

Client Contact Information *(Address, Telephone Number, E-Mail address, etc.)***:**

Information to be released to:

Leon County Sheriff's Office, FSU Police Department, Tallahassee Police Department, Liberty County Sheriff's Office, Quincy Police Department, Gadsden County Sherriff's Department, Wakulla County Sheriff's Office, Monticello Police Department, Jefferson County Sheriff's Office, Franklin County Sheriff's Office, Florida Fish and Wildlife Commission and Division of Alcoholic Beverages and Tobacco

Description of information to be released:

Assessments, Treatment Plans & Reviews, Progress & Group Notes, Drug Testing Reports and Progress Reports

Purpose of Information: To facilitate treatment

Expiration Date Of Authorization (One Year Or Less): _____

Print Name of Client Representative (If applicable): _____

_____ _____

Signature of Client or Client's Representative **Date**

_____ _____

Signature of Witness **Date**

You have the right to revoke (take back) this authorization. You must make this request, in writing, to the agency you wish to take back the authorization. Some health care providers may choose to not provide services to you or not enroll you in programs if you refuse to provide required information. If you wish to discuss revoking this authorization or refuse to sign this form, you can ask for assistance from DISC Village's, Inc. Privacy Officer who can go over this information in more detail.