AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Comprehensive Childcare Associates – 2020 Cattlemen Road Suite 600 – Sarasota, Florida 34232
Office (941)955-5191 – Fax (941)366-7582 – www.ccapeds.com

Please provide thorough and accurate information when filing out this form. Comprehensive Childcare Associates will only process valid and complete Authorization forms.

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Social Security Number: _____ Daytime Phone Number: _____

RELEASE INFORMATION *FROM*:

☐ Comprehensive Childcare Associates

☐ Other:

Organization/Name _____

Address _____

City, State, Zip _____

Phone (required) _____

Fax _____

RELEASE INFORMATION *TO*:

☐ Comprehensive Childcare Associates

☐ Other:

Organization/Name _____

Address _____

City, State, Zip _____

Phone (required) _____

Fax _____

TYPE OF INFORMATION TO BE RELEASED (I may be charged a fee for the cost of copying and postage)

☐ **All Health Information**

☐ Health Information related to the following treatment(s) or conditions _____

☐ Laboratory/Diagnostic Tests _____

☐ Other _____

The release of sensitive health information requires specific patient consent. If you would like to release this type of information, please initial the following item(s):

_____ *Drug*/Alcohol Abuse _____ Sexually Transmitted Diseases (including AIDS and HIV)

_____ Mental Health (including pain management or psychiatry records)

Purpose or Need for this Information: ☐*Transfer of Care* ☐*Copies for Own Use* ☐ *Other* _____

* I permit the information to be released for the specific purpose stated above. Any other use of this information without my written consent is prohibited.
* I recognize that health information pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
* I realize that I have a right to a copy of this Authorization.
* I am aware that the Authorization will expire in 90 days unless otherwise specified: _____ (date/event).
* I understand that I may revoke or modify this Authorization at any time in writing, except to the extent that action has already been taken to comply with it.
* I voluntarily sign the Authorization and understand that my health care will not be affected if I do not sign it.

By signing this document, I acknowledge that I have read and agreed to the Authorization's terms.

_____ _____ _____

Date ***Signature of Patient or Legally Responsible Party*** ***Authority to sign, if not Patient***