



## Substance Abuse Authorization to Obtain / Release of Information

Client Name: \_\_\_\_\_

Client DOB: \_\_\_\_\_

By signing this authorization, I hereby give permission to Families First of Florida to Release and/or Request written and/or verbal protected health information.

**\*\*\*\*\* Please note: Only one agency or person per release\*\*\*\*\***

Agency or Person: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**Fill in info on who records will be released to or requested from.**  
**Only one Agency or Person per form**

**Check what is to be released/requested**

**MUST specify information to be released/requested.**

Substance Abuse Treatment Plan

Substance Abuse Monthly Reports (Progress Summary)

Substance Abuse Mental Health Assessment

Substance Abuse Discharge Summary

Substance Abuse Drug Screening Results

Substance Abuse Assessment Results

\_\_\_\_\_ Other (must specify)

**Must be specific**

This information will be used for the purpose of coordinating my care, providing services to me, and/or evaluating my needs. I understand that I have the right to refuse to sign this authorization and that my refusal to sign will not impact my right to treatment. I understand that any disclosure is bound by Title 42 of the Code of Federal Regulations, Part 2.

By signing this authorization, I agree to allow FFF to release/request records containing mental health, substance abuse, HIV, reproductive health care and gender affirming information. Although the recipient is not permitted to release the information without additional written consent, Families First of Florida cannot be held responsible for further use or re-disclosure by the recipient. FFF will send/provide Electronic Health Information (EHI) in a secure manner, however if the client or the client's personal representative who has been granted the authority to make healthcare decisions asks FFF to send EHI to an unsecure destination/device then FFF cannot be held liable for third party release or redisclosure.

This authorization is valid for one year from the date of my signature.

This authorization can be revoked at any time upon written notice, revocation does not affect release/request prior to the notice.

**Sign and date your signature here**

Signature of Client \_\_\_\_\_  
(Mandatory)

Signature Date \_\_\_\_\_

**Telephone Number** (813) 290-8560 **Choose** Records (Option 5)  
**Fax Number** 813-354-2416 **Email Address** [records@familiesfirstfl.com](mailto:records@familiesfirstfl.com)  
[www.familiesfirstfl.com](http://www.familiesfirstfl.com)