Release of Information

Patient Information

Patient Name: _____ Date of Birth (DOB): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

I, [ ], do hereby authorize A New Hope Psychiatric Services (ANHPS) to either (Check One or Both):

- ☐ Obtain
- ☐ Release

information checked below from my records, or those of my child, or the individual for whom I am a legal guardian:

- ☐ Medical Records
- ☐ Progress notes/Summaries/reports
- ☐ Laboratory records/reports
- ☐ Diagnosis
- ☐ Treatment plans/discharge summaries
- ☐ Mental health/psychological records
- ☐ Assessments/Evaluations
- ☐ Other (please specify): _____

Receiving Information

The individual or position and organization from which information is to be obtained, released, or both:

Name of Entity: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

If an email address is provided, I understand that electronic communication carries inherent privacy risks, including potential interception, misdelivery, or unauthorized access, and I authorize the exchange of information via email despite these risks.

Purpose of Exchange:

- ☐ Continuity of Care
- ☐ Treatment Coordination
- ☐ Consultation
- ☐ Other (Specify): _____

Please return information to:

A New Hope Psychiatric Services

Phone number: 352-234-8815

Mailing address: 7901 4th St N, STE 13740, St. Petersburg, FL 33702 Fax number: 877-749-1902

Email: admin@anewhope.group

A NEW HOPE
PSYCHIATRIC SERVICES

Authorization & Important Information

Right to Revoke Authorization:

I understand that I have the right to revoke this authorization at any time by providing written notice to "A New Hope Psychiatric Services". However, any actions taken prior to the revocation based on this authorization will not be affected.

HIPPA Privacy Notice

I understand that the information exchanged pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Important Information

- This authorization is voluntary, and I may refuse to sign it.
- I understand that I am entitled to receive a copy of this authorization after I sign it.
- I understand that the exchange of information may include sensitive information related to mental health, HIV/AIDS status, substance abuse treatment, etc., and I authorize the exchange of such information as indicated above.
- Treatment, payment, enrollment, or eligibility for benefits and services may or may not be contingent upon completion of this authorization.

Signature of Patient or Legal Representative

Signature: _____ Date: _____

Witness (if applicable)

If someone other than the patient or legal representative is witnessing the signature

Witness Name: _____ Date: _____

Signature: _____

Expiration of Authorization:

This release is effective from the date of signature and is valid for a period of one year for ongoing service provisions, up to 90 days for a one-time release of information, or as required by law or court order.

Office: 352-234-8815 Fax: 877-749-1902
100 East Pine Street
Suite 110
Orlando, Florida 32801