Cristina Mantilla, LLC.

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient / Client Name: _____SS# _____ DOB_____

I hereby give permission for: Cristina Mantilla, LLC Phone: 727-505-3465 Fax: 1-866-926-7270

Mailing Address: Po Box 280 Port Richey, Florida 34673

This information is to be released to: _____
(Agency / Individual releasing information)

_____
Mailing Address Phone Fax

To disclose medical, including HIV, ARC, and / or AIDS diagnosis_____ (initials), psychiatric, psychological, educational, alcohol and / or drug abuse information, or any other records of sensitive nature, and may be released by copies, viewing of records, or verbal exchange.

For the Purpose of: Continuity of Care_____

I further authorize the above named agencies / individuals to share authorized information with each other:
Yes ___ No____

The specific information is to be disclosed:
_____ Psychiatric Evaluation ____ Treatment Updates _____ Treatment Plan _____Diagnosis _____ Medication

_____ Treatment Summary _____ Initial Assessment _____HIV / AIDS test results _____ Lab Results / X-Ray

_____ most recent IEP / or 504 plan ____ Current Report Card or progress Report _____ Copy Most Recent discipline History _____ Drug / Substance Abuse History
Other:
_____

I understand that my records have a privileged and confidential status and that I am waiving that status for the purpose contained within this authorization. I understand that I have the right to refuse to sign this authorization. My refusal will in no way hinder me from receiving treatment. I understand that my records may be revoked at any time upon written notification at the facility in which I received the treatment, but revocation has no effect on action already taken as a result of this authorization. I understand that law prohibits any redisclosure of this information by the receiving agency, not by the Federal Privacy Law, but by other federal and state laws.

This authorization is valid until:
_____

_____ ___ / ___ / ___ _____ ___ / ___ / ___
Signature of Patient / Client Date Signature of Witness Date

_____ ___ / ___ / ___ _____
Signature of Legal Guardian Date Relationship to Patient / Client

If the patient / client is a minor or unable to sign a legal representative / guardian must be substantiated with legal documentation accompanying this authorization.