BAY AREA BEHAVIORAL SERVICES
135 North Moon Avenue Brandon, Florida 33510

AUTHORIZATION FOR RELEASE OF INFORMATION
(From Bay Area Behavioral Services to Third Party)

I, (Responsible Party) _____hereby authorize the disclosure and release of protected health information as follows:

FROM: Bay Area Behavioral Services - Outpatient Mental Health Practice

TO: Insurance Company/Individual/Agency: _____
AT: Address: _____

REASON: To provide clinical and therapeutic information regarding the named client.

Client Name: _____ Client DOB: _____

I, as the responsible party for this client, fully authorize the release of the following checked and initialed confidential information regarding the named client to the above named requesting entity/individual.

Check Items to be Released and Initial:

☐ Mental Health Records Initials of Responsible Party: _____
☐ Other Information: Initials of Responsible Party: _____

Specify: _____

Bay Area Behavioral Services will keep all information obtained through the clinical process in the strictest of confidence. We will not release any confidential/protected health information gained through the therapeutic process to any person(s) without the prior signed authorization of the responsible party/representative.

I understand that I, as the responsible party, may revoke this authorization at any time by providing written notice to Bay Area Behavioral Services; and that this authorization automatically expires on the date of discharge.

_____ _____
Signature of Responsible Party **Date**

_____ _____
Printed Name of Responsible Party **Date**

_____ _____
Witness Signature **Date**

_____ _____
Witness Printed Name **Date**