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

AUTHORIZATION FOR RELEASE OF INFORMATION

I, (Responsible Party) _____ , hereby authorize the release of any information requested by Bay Area Behavioral Services in order to provide clinical and therapeutic services to (Client Name) _____. The following is a list of information that I (Responsible Party)_____ am authorizing at this time to be released from (Agency/Office)_____to Bay Area Behavioral Services:

☐Mental Health Records and/or Psychiatric Records

☐Psychological and Developmental Testing Records

☐Comprehensive Behavioral Health Assessment

☐Educational Records

☐Medical and/or Hospital Records

☐Child Protective Investigation Records

☐Community Based Care Case Management Records

☐Department of Juvenile Justice Records
(Authorized Representative to check each box above)

Bay Area Behavioral Services will keep all information obtained through the clinical process in the strictest of confidence and will not release any confidential information gained through the therapeutic process to any persons without the prior authorization of the representative signing this form.

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**