CGR BEACON CLINIC, P.A.
P.O. BOX 496080
PORT CHARLOTTE, FL 33949
941-629-7855/941-6299589 FAX

AUTHORIZATION FOR REQUEST OR RELEASE OF INFORMATION

DATE____________________ DATE OF BIRTH____________________

CLIENT NAME____________________ SS#____________________

I hereby request and give permission to The Beacon Clinic or any of its subsidiaries or affiliates and clinician(s) performing services on behalf of Beacon Clinic in connection with my treatment to:

(Please check box) [ ] **Disclose information to:** [ ] **Obtain information from:**
If information is to be shared, verbally or in writing, check both blocks.

(Name if Person or Agency)____

(Address of Person or Agency---- **required**)________________________________

Please indicate with check mark what is to be released:

[ ] Substance Abuse Evaluation/Drug/Alcohol
[ ] Group Attendance Report Only
[ ] Treatment Recommendations/ Treatment Plan
[ ] Outpatient Mental Health
[ ] Diagnostic Assessment/ Psychiatric Evaluation
[ ] Labs Reports, Diagnostic Tests, etc.
[ ] Geriatric Residential Treatment Services Treatment
[ ] Therapeutic Family Care Treatment

[ ] Crisis Stabilization Unit Admit (Include **dates**) ______________________________

[ ] Progress report on my treatment [ ] Discharge Summary [ ] Financial Information

The purpose or need for disclosure is: (MUST BE COMPLETED TO BE VALID)

[ ] To permit continuity of care
[ ] To permit case management
[ ] To maintain family involvement
[ ] To keep EAP/ referral source informed
[ ] For or pertaining to insurance claims
[ ] Legal reasons (i.e., disability, accident, etc.)
[ ] Other____

I may revoke this consent at any given time except to the extent that action has been taken in reliance upon it. If I do not revoke it , this consent will expire 90 days after I have terminated with all providers with all providers affiliated with Beacon Clinic.

CLIENT SIGNATURE______________________________ DATE____________________

PARENT/GAURDIAN /CONSERVATOR OR AUTHORIZED REPRESENTIVE
SIGNATURE (WHEN REQUIRED) ______________________________DATE______________

WITNESS SIGNATURE____________________________________DATE______________

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentially of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42cfr Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains. A general authorization for the release of medical or other information is not sufficient for this purpose.

**Thomas A. Willingham, M.D., Kathleen Kaloski ARNP, B.C., Charlene Rosenfield ARNP, B.C.,
Gerald N. Ross Ed.D., Donna Chimato MS, LMHC, Chantelle Grant LCSW, Christina Rooney MA LMHC
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