**Because You Can, LLC**
**Authorization to Release Medical Information**

I hereby authorize _____ to release medical, psychological, psychiatric, developmental-rehabilitative alcohol and/or drug abuse, human immunodeficiency virus (HIV) testing and treatment, ARC (AIDS related condition), and/or acquired immunodeficiency syndrome (AIDS) information as it concerns:

Patient Name: _____ Date of Birth: _____

Release to: Because You Can LLC.
5225 Central Ave
St. Petersburg, Fl, 33710

_____ Relationship to Patient

_____ Home Phone

_____ Cell Phone

Purpose of Use or Disclosure (eg. Continuity of Care): _____

If the purpose listed above includes "marketing," Because You Can, LLC [check one box] will □ or will not □ receive payment as a result of using or disclosing this information. This does not include payment for any services provided to the above named patient.

Information to be Released: □ History and Physical □ Discharge Summary (ies)
□ Outpatient Care Clinic □ Abstract (includes History & Physical, Discharge Summary)
□ Developmental-Rehabilitative □ Other_____ (eg. Pathology Report, Laboratory or other reports as applicable)

I understand that all medical, surgical, psychiatric, and psychological information is confidential and that patient records are the property of Because You Can, LLC (BYC) and its related corporate entities. I will not hold BYC, its employees, staff, or representatives responsible for any damage, mental or physical, which may be caused by the release of patient records and the information contained therein.

I understand that my authorization for release may be revoked at any time by written request to BYC, but may not be revoked to include the release allowed by this document. Also, if this authorization is permission for BYC to disclose information to an insurance company, in order for me to obtain insurance coverage, the insurance company may still have the legal right to use the information to contest my coverage.

I understand that the person or organization that receives the information because of this authorization may disclose this information to other people or organizations without my knowledge or consent. Therefore, I hereby release BYC, its employees, staff, and representatives from all liability relating to or arising out of this release of information contained in BYC patient records.

I understand I can refuse to sign this authorization and I do not need to sign this authorization to receive treatment services from BYC. However, if the only purpose for providing the service is to obtain information in order to release information to myself or a third party, then I understand that I must sight the authorization in order to receive the service.

This authorization will expire in twelve (12) months following the date of signature, unless otherwise specified below.

Expiration Date: _____

Signed: _____ _____
Patient/Parent/Legal Representative — Date / Time

_____ _____
Relationship to patient, if not self — Date / Time

Witness: _____ _____
Signature — Date / Time