BYC
BECAUSE YOU CAN

5225 Central Ave, Saint Petersburg, FL 33710

Authorization for Release of Information Form

I hereby authorize _____ to release medical, psychological,
Name of provider/facility
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's name: _____ **Date of birth:** _____
Last *First* *MM/DD/YYYY*

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

_____

Relationship to patient (if not self) *Home phone* *Cell phone*

Purpose of use or disclosure (e.g. – continuity of care): _____

If the purpose listed above includes "marketing", Because You Can, LLC ☐ **will** ☐ **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

☐ Outpatient care clinic

☐ Developmental-Rehabilitative

☐ Discharge summary(ies)

☐ Abstract (includes history & physical and discharge summary)

☐ Other (e.g. – 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 and its related corporate entities. I will not hold Because You Can, LLC, 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 Because You Can, LLC, but may not be revoked to include the release allowed by this document. Also, if this authorization is permission for Because You Can, LLC 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 Because You Can, LLC, its employees, staff, and representatives from all liability relating to or arising out of this release of information contained in Because You Can, LLC 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 Because You Can, LLC. 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 cite 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: _____
MM/DD/YYYY

Signed:

_____
Patient/Parent/Guardian/Legal representative *Date* *Time*

_____
Relationship to patient (if not self)

_____
Witness *Date* *Time*