Peace River Center®
COMPASSIONATE PEOPLE • POSITIVE IMPACT

PRC Staff only
Appt. date: _____
With _____
Time:_____

Registration Form

DOB: _____Social Security # _____

Gender: ☐Female or ☐male (*please circle one*)

First Name: _____

Middle Name: _____

Last Name: _____

Primary Phone: _____ Alternate Phone: _____

Do you want a reminder call: ☐Yes or ☐No

Address: _____

City: _____Zip Code: _____

County: _____

Marital Status: _____Primary Language: _____

Race: _____

Do you have an E-mail Address? ☐Yes or ☐No

If you do please enter here: _____

How many dependents: _____

Are you currently employed? ☐Yes or ☐No

If you do please provide information _____

Did you have another Type of Income? ☐Yes or ☐no

If you do what type of income: _____

Referral by: _____

Client Signature: _____ Date: _____

Rev. 03/28/2023

Primary Care Physician

PCP:_____

(*First Name and Last Name of Primary Care Physician*):

Address: _____

City: _____ **Zip code:**_____

Telephone number: _____

Fax Number: _____

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Adult General Consents/AOB

Patient Consents

*I give permission to contact me and / or my Primary Care Physician for the purpose of follow-up care. I have been informed of the importance of these contacts as ways to improve continuity of care. I realize I have the right to revoke this consent at any time.
*I will notify Peace River Center if my address or telephone numbers are changed.
*I give my consent for Peace River Center to provide me with services.
*I understand that I must inform my primary therapist when I am receiving other mental health services, either from within Peace River Center or from a practitioner outside of the Center.
*I understand that if now or in the future I have a relative who is employed by Peace River Center it is strongly recommended that I receive service through another provider. I may, however, request and receive services at Peace River Center with the understanding that m case will receive no special privileges and will be handled following regular policies and procedures.
*I consent to having my picture taken and stored on my page of the Electronic Medical Record for Peace River Center.
*I consent to being contacted by the following methods: Phone, email, text.
My Preferred method of communication is: ___Phone ___Email ___Text
*I consent to receive calls/texts/emails from Peace River Center for my protected healthcare and other services at the contact information provided, including my wireless number. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

I acknowledge that I have read my consents as a patient of Peace River Center and I understand them. ___ Yes ___ No

HIPAA Acknowledgement

I acknowledge that I was provided a copy of Peace River Center's Notice of Privacy Practices to meet the HIPAA requirements under 45 CFR 164.520 (c) (2) (I), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices and agree to its terms. ___ Yes ___ No

Patient's Rights and Privileges

As a patient of Peace River Center you have the following rights:

1. The right to respect and dignity at all times.
2. The right to receive quality treatment.
3. The right to impartial access to treatment, regardless of race, sex, handicap, age, or ethnicity.
4. The right to receive individualized treatment, within the least restrictive environment. Treatment will include an individualized treatment plan that will be viewed at least every 6 months.
5. The right to be provided with the appropriate qualified, competent and experienced professional clinical staff to implement and supervise my treatment plan.
6. The right to file a grievance if I feel my therapist is not acting in my behalf.
7. The right to be informed by my physician or counselor about any proceedings to hold me involuntarily.
8. The right to access to my clinical record.
9. The right to be free from neglect; exploitation; and verbal, mental physical or sexual abuse while I am receiving care, treatment, or services.
10. The right to strict confidentiality of all information about me except under the following exceptions:
    a. Where there is a threat to harm another individual or yourself.
    b. Where there are suspicions or knowledge of abuse (child, elderly, disabled, etc.)
    c. Where there is a court-order for information
    d. Where there is medical emergency.

*I understand that these exceptions are required by law.
*I do hereby acknowledge that I have read my rights and privileges as a patient of Peace River Center and I understand them.
*I understand I have the right to report any violations of my patient rights to the toll-free Abuse Registry number listed:
Abuse Registry: 1-800-96-ABUSE
*I understand my rights and privileges ___ Yes ___ No

Missed Appointments

All appointments must be canceled 24 hours prior to your appointment date and time. If you do not cancel your appointment, you may be a walk-in only client.

Billable Services

All services are billable. The Registrar may not know all the services performed the day of your appointment until the clinician or doctor completes the necessary forms and bills for the services. These services will show up on your monthly statement and are due upon receipt.

Financial Agreement

In consideration of the services to be rendered to the client, I individually promise to pay the client's account at the rates stated in Peace River Center's (PRC) price list (known as the 'Charge Master') effective on the date the charge is processed for the service provided, which rates are hereby expressly incorporated by reference as the price term of this agreement to pay the client's account. Some special items will be priced separately if there is not a price listed on the Charge master, or if the charge is listed as zero. An estimate of the anticipated charges for services will be provided to me upon my request from PRC. Estimates may vary significantly from the final charges based on a variety of factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.
If supplies and services are provided to me and I have coverage through a governmental program through certain private health insurance plans, PRC may accept a discounted payment for those supplies and services. In this event, any payment required from me will be determined by the terms of my governmental program or private health insurance plan. If I am uninsured and not covered by a governmental program, I may be eligible to have my account discounted or forgiven under PRC's self-pay collection policy in effect at the time of treatment. I my request information about this policy from PRC.
As a courtesy to me, PRC may bill my insurance company, but is not obligated to do so. Regardless, I agree that except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I agree to pay any services that are not covered by my insurance company. This includes, but is not limited to coinsurance, deductibles, non-covered benefits due to policy limits or policy exclusions as well as failure to comply with my insurance plan requirements. I understand PRC's right to review my credit bureau files for financial information for the purpose of collecting unpaid debts. I also agree that if PRC must initiate collection efforts to recover amounts owed by me, then in addition to amounts incurred for the services rendered I will pay: (a) any and all costs incurred by PRC in pursuing collection, including, but not limited to, reasonable attorneys' fees, and (b) any court costs or other costs of litigation incurred by PRC that applicable rules or statutes permit PRC to recover.

Assignment of Benefits

In executing this assignment of benefits, I am directing the health insurance carrier or other health benefit plan providing my coverage (including, but not limited to, any employer, employer group or trust sponsored or offered plan) to pay PRC directly for the services PRC provided to the patient during this admission. In return for the services rendered and to be rendered by PRC, I hereby irrevocably assign and transfer to PRC all right, title, and interest in all benefits payable the healthcare rendered, which are provided in any and all insurance policies and health benefit plans from which I am entitled services or I am entitled to recover. I understand that any payment received from these policies and/or plans will be applied to the amount that I have agreed to pay for services rendered during this admission, as further described in the Financial Agreement section. This assignment shall be for the purpose of granting PRC an

independent right of recovery against my insurer or health benefit plan, but shall not be construed as an obligation of PRC to pursue any such right of recovery. In no event will PRC retain benefits in excess of the amount owed to PRC for the care and treatment rendered during the admission. If a third party payer (such as an insurance company , employer group, trust sponsored or offered plan) may be obligated to pay some or all of these charges, I agree to take all actions necessary to assist PRC in collecting payment from any such third party payer. I hereby appoint PRC as my authorized representative to pursue, if it so chooses, all administrative remedies, claims and/or lawsuits on my behalf and at PRC's election, against any responsible third party, medical insurer, or employer sponsored medical benefit plan for the purpose of collecting any and all PRC benefits due me for the payment of the chargers referred to in the Financial agreement section. If PRC elects to pursue a claim or lawsuit against a third party payer as authorized representative, I agree to execute a special power of attorney, if requested, authorizing PRC to take all actions necessary or appropriate in pursuit of such claim or lawsuit, including allowing PRC to bring suit against the third party payer in my name. I agree to pay over to PRC immediately all sums recovered in any claim or lawsuit brought on my behalf by PRC (up to the amount of PRC's charges, plus expenses and attorneys' fees).

I have read and been given the opportunity to ask questions about this assignment of benefits. ___ Yes ___ No

Is the client participating in SAMHSA funded Project? ___ Yes ___ No
If no, please skip this section.

In signing this Consent for Treatment, I am consenting to participating in the SAMHSA funded service intervention to assist in my engagement and retention in mental health treatment services. This program is funded by a grant with the Substance Abuse and Mental Health Services Administration, and as such, data is collected as part of the program. I consent to this data collection and the provision of data information back to the Substance Abuse and Mental Health Services Administration for the purposes of grant tracking and de-identified result gathering.

I have signed this Document freely and without inducement, other than the rendition of services by PRC.

___ Yes ___ No

_____ _____ _____
Patient Name Date of Birth Social Security Number

_____ _____
Signature of Patient or Guardian Date

_____ _____
Signature of Witness Date

Credible Client Portal
Authorization Agreement, Release of Liability and Terms and Conditions of Use

You are requesting access to portions of your health information, as well as the ability to communicate with your Peace River Center ("PRC") providers regarding your health information by using an Internet-based electronic application called the Credible Client Portal. In order to obtain access to the Credible Client Portal, you are required to acknowledge that you have read these Terms and Conditions and find them acceptable. PRC reserves the right to make any changes to these Terms and Conditions at any time without notifying you or obtaining your agreement. Any changes to the Terms and Conditions will be posted on the PRC website.

We will communicate with you by e-mail and/or messaging on this site. You agree that all agreements, notices, disclosures and other communications that we provide you electronically satisfy any legal requirements that such communications be in writing. The Client Portal is intended to save you time and ease communications between you and your provider(s). It does not allow for any type of diagnosis or mental health advice, and should never be used in an emergency situation. You may contact the appointment line via telephone at any time.

Privacy

The privacy of your health information is extremely important to us. PRC will use and disclose your health information in order to provide you with health care services. PRC will maintain your health information in strict confidence and will not disclose it to any unaffiliated third party unless you authorize that person to receive your health information or it is permitted to be disclosed by law. Please review PRC's Notice of Privacy Practices for an explanation of how, when, and why we use and disclose your health information. All electronic messages sent and received within the Credible Client Portal that contain health information are subject to all state and federal laws governing the security and confidentiality of medical records.

Use/Access

The Credible Client Portal should never be used for urgent matters. For all urgent medical matters, contact your provider's office by phone, and/or go to the emergency department of a local hospital, and/or dial 911.

All information in the Credible Client Portal is provided "as is" without warranty of any kind, and is meant for use only to support your relationship with your provider. Your reliance on the information provided in the Credible Client Portal is not a replacement for proper medical attention. The information displayed in the Credible Client Portal may not be the complete medical record. Therefore, you must contact PRC directly for official and complete copies of your medical record, or in regard to discrepancies with the medical information listed in your record.

The Credible Client Portal may not be available to you at all times due to system failures, procedures, maintenance, or other causes beyond PRC's control. Access is provided on an "as-is, as available" basis, and PRC does not guarantee that you will be able to access the Credible Client Portal at any particular time.

PRC will make its best effort to provide a timely response to your electronic messages. In some situations, the staff that must respond to a message may not be immediately available.

Your electronic messages may be shared with the PRC staff member that assists your provider in providing services to you. Your messages will only be available to designated professionals. If your provider is out of the office or unavailable, messages sent within the Credible Client Portal may be routed to other appropriate and authorized caregivers within PRC in order to facilitate a timely response to your request.

Inappropriate Use/Termination

Credible Client Portal access is granted for the purpose of furthering your medical care. Use of the Credible Client Portal unrelated to this purpose may result in the suspension or termination of access privileges. Improper use includes, but is not limited to, the use of inappropriate, threatening or abusive language, requesting appointment times that are frequently cancelled, and any other use that PRC determines in its sole discretion constitutes a disruption to PRC operations. PRC reserves the right, in its sole discretion, to terminate a user's access to all or part of the Credible Client Portal website, with or without notice.

Credible Client Portal ID and Password

You will be provided with an access code when you initially enroll in the Credible Client Portal. The login name and password you choose will be used to access your health information in the Credible Client Portal and are unique codes that identify you in the Credible Client Portal system. Any inquiries and entries you make in the Credible Client Portal will be logged with your identity and may become part of your official medical record. Therefore, it is extremely important that you keep your login name and password completely confidential. Anyone with access to your login name and password will be able to access your health information, as well as read your messages and send new message as if they were you. It is your responsibility to prevent disclosure of your login name and password, and to change your password if you feel that the security of your password has been compromised. You may change your password at any time by contact the Health Information Services/Medical Records Department.

Verification of Identity

Your enrollment in the Credible Client Portal is contingent on verification of your identity by a PRC employee. You may access the Peace River Center Credible Client Portal through our website at: www.peacerivercenter.org.

Secure Communications

All communication between you and your PRC providers occur over a secure connection. However, if you elect to receive Internet e-mail messaging notifying you that new information is available in your Credible Client Portal account, please take the following into consideration. Although these e-mail messages will not contain your medical information, the notification that new medical information is available by accessing the Credible Client Portal may be information that you do not want others to know. Therefore, you should take this into account when providing PRC with your e-mail address. All of the health information available to you is accessed within your Credible Client Portal account and is protected and securely maintained by PRC. Although the Credible Client Portal is configured to be secure from unauthorized access, PRC is not responsible for:

- Absolute security of all electronic communication transmissions between the client and PRC;
- Unauthorized disclosure resulting from a user not logging out of an active session;
- Unauthorized disclosure resulting from a lost, stolen, or shared login name and/or password;
- Unauthorized disclosure resulting from information printed from the Credible Client Portal by the user;
- Unauthorized disclosure resulting from personal computer settings or installed software products that may compromise information security; or
- Similar events beyond the substantial control of PRC.

Our personnel will never ask you for your password in an unsolicited phone call or in an unsolicited e-mail. Remember to sign out of your account and close your browser window when you have finished your session to help ensure that others cannot access your personal information.

If you are not receiving email notifications that you have a message in the Client Portal, please check your email account settings. Spam blocking software may be blocking legitimate emails from Peace River Center Credible Client Portal. To receive emails, please add credibleportal.com to your contact list, address list, and/or "Do Not Block" list.

For ease of use and to maintain security of your personal health information, the following guidelines should be followed:

- Advise us of any changes in you primary contact email address
- Use caution when communicating highly sensitive or personal information via the Peace River Center Credible Client Portal
- Always follow up with the appointment line if an inquiry/message through Peace River Center Credible Client Portal is not responded to within 3 business days.
- Do not store messages on any device or computer not personally owned.
- Never use the Client Portal for emergency needs.

Property Rights

The content and materials available on the Credible Client Portal website are protected by copyrights, trademarks, patents, trade secrets, or other proprietary rights and laws. You may download, use and copy materials from the Credible Client Portal website for your personal, noncommercial use only, provided all copies include our copyright information and logo, and the information is not altered in any way. Materials cannot be copied and redistributed without the express written permission of PRC. Except as authorized in this paragraph, you are not being granted a license under any copyright, trademark, patent, or other intellectual property right in the material or the products, services, processes or technology described in this website. All such rights are retained by PRC, its affiliates and subsidiaries, and/or any third-party owner of such rights. You may not create framed links to the Credible Client Portal website without the express written permission from PRC.

Disclaimer of Warranties and Limitation of Liability

PRC makes no representations or warranties about the suitability of the Credible Client Portal website materials for any purpose. The materials on the Credible Client Portal website are provided: WITHOUT WARRANTY OF ANY KIND, EITHER EXPRESSED OR IMPLIED, INCLUDING, BUT NOT LIMITED TO, THE IMPLIED WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE OR NONFRINGEMENT. PRC does not warrant the accuracy or completeness of the information, text, graphics, links and other items contained within these materials.

IN NO EVENT SHALL PRC BE LIABLE FOR ANY DAMAGES WHATSOEVER, INCLUDING SPECIAL, INDIRECT, CONSEQUENTIAL OR INCIDENTAL DAMAGES OR DAMAGES FOR LOSS OF PROFITS, REVENUE, USE OR DATA WHETHER BROUGHT IN CONTRACT OR TORT, ARISING OUT OF OR CONNECTED WITH ANY WEBSITE OF PRC OR THE USE, RELIANCE UPON OR PERFORMANCE OF ANY MATERIALS CONTAINED IN OR ACCESSED FROM ANY WEBSITE OF PRC.

PRC may make any changes to these materials, or the products and services described within these materials, at any time without notice. PRC makes no representation or commitment that it will update the information

contained herein. Your sole and exclusive remedy for dissatisfaction with the Credible Client Portal is to stop using the Client Portal.

Use of Information Provided via the Internet
Do not send PRC any proprietary information (ie. Copyright, Patent). Any such information provided may be reproduced, used and distributed by PRC for any purpose without restriction.

Endorsements/Other Sites
Some of the product and service marks contained herein are not PRC marks and are the marks of their respective owners. References that PRC may make to any names, marks, products or services of third parties or hypertext links to third-party sites or information do not necessarily constitute or imply endorsement, sponsorship or recommendation of the third party, information, product or service.

Legal Compliance
Users are prohibited from posting or transmitting any unlawful, threatening, libelous, defamatory, obscene, scandalous, inflammatory, pornographic or profane material on the Credible Client Portal website. If something a user posted or transmitted results in or encourages conduct that is considered a criminal offense, civil liability or otherwise violates any law, the website owner will fully cooperate with law enforcement authorities or court order requesting or directing the website owner to disclose the identity of anyone posting such information or materials.

Choice of Law and Forum
The terms and conditions set forth above shall be governed by and construed in accordance with the laws of the State of Florida. All users expressly agree that the exclusive jurisdiction of any claim or action arising out of or relating to these terms and conditions or any use of this website shall be filed only in the state or federal courts located in the State of Florida. Further, all users agree and submit to the exercise of personal jurisdiction of such courts for the purpose of litigating any such claim or action.

Severability and Integration
Unless otherwise specified herein, the terms and conditions stated above constitute the entire agreement between the user and PRC with respect to this website and supersedes all prior or contemporaneous communications and proposals (whether oral, written, or electronic) between the user and PRC with respect to this website. If any part of the terms and conditions is held invalid or unenforceable, that portion shall be construed in a manner consistent with applicable law to reflect, as nearly as possible, the original intentions of the parties, and the remaining portions shall remain in full force and effect.

Alternative User Authorization
If you would like a family member or another type of user to have access to your electronic medical records using the Credible Client Portal, please contact the Health Information Services/Medical Records Department to complete the Alternative User Authorization form.

Minor Clients
Florida regulations allow natural parents' or legal guardians' access to a child's health information. A separate authorization form is required for each parent or guardian. If you would like access to your electronic medical

record information or the electronic medical record of a minor for whom you are the legal guardian, please complete the Minor Child Authorization Form. You will be required to certify that you are the parent or legal

guardian of the child listed. I understand that this electronic access will end upon my child's/the client's 18th birthday.

Client Authorization

I understand that by signing this form I am requesting access to my electronic medical record. I agree to the terms and conditions of the Credible Client Portal which have been shared with me. I understand that this access will be in effect until such time that I notify PRC via written letter, to the address provided below, to terminate access. Access to the Credible Client Portal may be terminated at any time.

I agree that I am responsible for the security and privacy of my username and password, as well as the information I obtain, copy, or print from Peace River Center Credible Client Portal. I understand that information released to me is no longer protected by state and federal privacy laws.

Client Signature _____ Date _____

Please Print Client's Full Name _____ Date _____

Client Email Address _____ Date _____

Declination of Services

At this time, I do not wish to enroll and have access to my information via the PRC Credible Client Portal. If I change my mind in the future, I will contact the office and schedule an enrollment appointment.

Reason for declining: _____

_____

Client Signature _____ Date _____

Internal use only: Verified and access entered by: _____ Date: _____

Client ID#: _____

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Please bring the following information to your appointment

1. Proof of residence (Driver's license or photo ID, Bill, Lease Agreement)
2. Proof of Income
3. Insurance Cards
4. Social Security Card
5. Authorization if required

********If client is a minor, they must be accompanied by the **LEGAL GUARDIAN** *****

Please call if you are unable to keep scheduled appointment. If you need immediate intervention, please call the CRISIS LINE at 863-519-3744.

Proof of Income accepted:

1. Income Tax Return
2. Proof of Medicaid Denial
3. Statement of Earnings (see office information below)
4. Paystubs (2)
5. Unemployment Statement
6. Food Stamp Letter

I understand that I am required to bring in the above information to the Intake appointment. I understand that if I fail to provide this information I may not be scheduled with the medical department.

*Statement of earnings may be requested from the Social Security office:

Social Security
550 Commerce Dr
Lakeland FL 33813
1-800-772-1213

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Proof of Income/Proof of Address

Did Client provide Proof of Income? ____ Yes (Please Attach) ____ No

Did Client state that they will provide POI at next appointment? ____ Yes ____ No

If no, please explain reason: _____

_____

_____

_____

Did Client provide Proof of Address? ____ Yes (Please Attach ____ No

Did Client state that they will provide Proof of Address at next appointment? ____ Yes (Please Attach) ____ No

If no, please explain reason: _____

_____

_____

_____

Did the client give verbal income information? ____ Yes (Please Attach) ____ No

If no, please explain reason: _____

_____

_____

_____

By signing below, you are verifying that the information provided is accurate to the best of your knowledge. If you did not provide Proof of Income and / or Proof of Catchment, it is your responsibility to bring this with you to your next scheduled appointment.

_____ _____

Client Signature Date

_____ _____

PRC Staff Signature Date

Client Name: _____ Client ID#: _____

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Zero Income

Client Name: _____ Client DOB: _____ Client ID: _____

Choose One:

- o Client has no proof of income.
- o Currently, I have no income of any kind and, while I am actively seeking employment, there is no definitive job offer at this time.
- o Currently, I have no income of any kind and will not be seeking employment at this time.

Household Information: Enter information on all members residing in your household.

Name	Relationship to Client	Date of Birth	Income
	SELF		

The following sources of funds pay for Client's basic necessities including: food, shelter, clothing, transportation, and medical care. (Please list name(s) and phone number(s) of person/organization providing basic needs.)

_____

_____

_____

_____

_____

_____

_____

I certify that the information provided in this form is accurate and true.

Signature of Client: _____ Date: _____

Mental Health Advance Directive Refusal

This Advance directive was reviewed with me and I have chosen to decline having an Advance directive.

Printed Name (Declarant): _____

Signature: _____ Date: _____

This advance directive was signed by _____ in our presence. At his/her request, we have signed our names below as witness. We declare that, at the time this advance directive was signed,

Dated at _____, this _____day of _____,

(County & State) (Day) (Month)

_____.

(Year)

Witness Signatures:

Witness 1:

_____ _____

Printed name of Witness 1 Signature of Witness 1

Witness 2:

_____ _____

Printed name of Witness 2 Signature of Witness 2

Advance Care Planning: Healthcare Directives

Advance care planning is not just about old age. At any age, a medical crisis could leave you too ill to make your own healthcare decisions. Even if you are not sick now, planning for health care in the future is an important step toward making sure you get the medical care you would want, if you are unable to speak for yourself and doctors and family members are making the decisions for you.

Many Americans face questions about medical treatment but may not be capable of making those decisions, for example, in an emergency or at the end of life. This article will explain the types of decisions that may need to be made in such cases and questions you can think about now so you're prepared later. It can help you think about who you would want to make decisions for you if you can't make them yourself. It will also discuss ways you can share your wishes with others. Knowing who you want to make decisions on your behalf and how you would decide might take some of the burden off family and friends.

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Phone: 863-519-0575
FAX: 863-499-2528

Authorization for Release or Exchange of Confidential Information

Patient/Client:_____ **Clinical Record#:**_____

DOB: _____ **Social Security #:**_____

HIS 0500 Rev. 08/10/17 **Confidential Do Not Release**

My signature on this form authorizes Peace River Center, to exchange information as indicated below, regarding my contacts/treatments in accordance with Florida Statutes and Federal Administrative Rules and Regulations to/from:

Name: _____

Street Address: _____

City/State/Zip _____

Phone: _____ **Fax:** _____

I also authorize the following entities as indicated by the check mark:

- ☐ Social Security Adminstration: 550 Commerce Drive, Lakeland, FL 33813, 800-325-0778
- ☐ Lakeland Regional Health: 1324 Lakeland Hills Blvd., Lakeland, FL 33805, 863-687-1100
- ☐ Department of Children & Families: 4720 Old Highway 37, Lakeland, FL 33815; 863-534-7100
- ☐ Lakeside Pediatrics: 2929 Lakeland Hills Blvd., Lakeland, FL 33805, 863-688-3550

Purpose of Disclosure: ☐ Legal ☐ Disability ☒Continutity of Care ☐Self ☐ Other:_____

Information may be Received as follows:
☐ Psychiatric/Psychological ☐Substance/Alcohol Abuse ☐ Medical/Hospital Information
☐ HIV/AIDS Test Results ☐Verbal Communications ☐Other: _____

Information may be Released as follows:
☐ Psychiatric/Psychological ☐Substance/Alcohol Abuse ☐ Medical/Hospital Information
☐ HIV/AIDS Test Results ☐Verbal Communications ☐Other: _____

Costs of Reproducing Medical Records: PRC reserves the right to charge a reasonable cost for reproducing records, set forth by Florida Administrative Code 64B8-10.003. By signing this Release of Information form, I understand that I may be responsible for any costs incurred.
Notice of Prohibition on Redisclosure: This information has been disclosed to you from records protected by Federal Rules governing confidentiality rules (42 CFR Part 2) and Florida Statutes (394.459, 396.112, 397.053, 381.609, 455.2416, 90.503, 90.242, and 45 CFR Part 160-164). The Federal Rules and State Statutes prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains. Information used or disclosed pursuant to this authorization may be subject to Redisclosure by the recipient and no longer be protected by the rules above. Peace River Center is released from all legal liability that may arise from the release of information requested. I understand I have the right to refuse this authorization or revoke it at a later date by submitting a written notice to the address above. I understand that I am not required to sign this authorization in order to receive treatment. When exchanging information where the patient/client is involved in treatment with other agencies/professionals to assist in coordinating treatment, this authorization may include verbal, written and/or electronic communication.
This authorization is valid for 5 year unless otherwise specified: _____.

Please answer the following questions if release or exchange of information is sought by the parent/legal guardian of a <u>minor</u> only:

1. Has patient/client been emancipated? _____Yes _____No
2. Has patient/client ever been convicted of a crime as an adult? _____Yes _____No
3. If the answer to question 2 is yes, is patient/client in the custody or under the supervision of the State Dept. of Corrections? _____Yes _____No
4. Has the patient/client ever been removed from your legal custody? _____Yes _____No

If the answer to any question is yes, do not release. Contact Health Information Services for guidance.

Patient/Client Signature:_____ **Date:** _____

Print Parent/Guardian Name: _____ **Relation to Patient/Client:** _____

Parent/Guardian Signature: _____ **Witness:** _____

Rev. 03/28/2023

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Phone: 863-519-0575
FAX: 863-499-2528

Authorization for Release or Exchange of Confidential Information

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HIS 0500 Rev. 08/10/17 **Confidential Do Not Release**

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Purpose of Disclosure: ☐ Legal ☐ Disability ☐ Continutity of Care ☐Self ☐ Other:_____

Information may be Received as follows:
☐ Psychiatric/Psychological ☐Substance/Alcohol Abuse ☐ Medical/Hospital Information
☐ HIV/AIDS Test Results ☐Verbal Communications ☐Other: _____

Information may be Released as follows:
☐ Psychiatric/Psychological ☐Substance/Alcohol Abuse ☐ Medical/Hospital Information
☐ HIV/AIDS Test Results ☐Verbal Communications ☐Other: _____

Costs of Reproducing Medical Records: PRC reserves the right to charge a reasonable cost for reproducing records, set forth by Florida Administrative Code 64B8-10.003. By signing this Release of Information form, I understand that I may be responsible for any costs incurred.
Notice of Prohibition on Redisclosure: This information has been disclosed to you from records protected by Federal Rules governing confidentiality rules (42 CFR Part 2) and Florida Statutes (394.459, 396.112, 397.053, 381.609, 455.2416, 90.503, 90.242, and 45 CFR Part 160-164). The Federal Rules and State Statutes prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains. Information used or disclosed pursuant to this authorization may be subject to Redisclosure by the recipient and no longer be protected by the rules above. Peace River Center is released from all legal liability that may arise from the release of information requested. I understand I have the right to refuse this authorization or revoke it at a later date by submitting a written notice to the address above. I understand that I am not required to sign this authorization in order to receive treatment. When exchanging information where the patient/client is involved in treatment with other agencies/professionals to assist in coordinating treatment, this authorization may include verbal, written and/or electronic communication.
This authorization is valid for 5 year unless otherwise specified: _____.

Please answer the following questions if release or exchange of information is sought by the parent/legal guardian of a <u>minor</u> only:

1. Has patient/client been emancipated? _____Yes _____No
2. Has patient/client ever been convicted of a crime as an adult? _____Yes _____No
3. If the answer to question 2 is yes, is patient/client in the custody or under the supervision of the State Dept. of Corrections? _____Yes _____No
4. Has the patient/client ever been removed from your legal custody? _____Yes _____No

If the answer to any question is yes, do not release. Contact Health Information Services for guidance.

Patient/Client Signature:_____ **Date:** _____

Print Parent/Guardian Name: _____ **Relation to Patient/Client:** _____

Parent/Guardian Signature: _____ **Witness:** _____

Rev. 03/28/2023