1370 Bedford Drive, Suite 106, Melbourne, FL 32940
Phone: (321) 253-8887 Fax: (321) 253-8878

CONSENT TO RELEASE AND RECEIVE CONFIDENTIAL INFORMATION

I,_____ (DOB: ____ / ____ / _____), hereby authorize

_____ and Baytree Behavioral Health to:
(Name of Provider)

[ ] Release To [ ] Receive From

Person/facility/agency: _____

Phone Number: ( ) _____ - _____ Fax Number: ( ) _____ - _____

Address (if known): _____

The specific information indicated below with regard to the services provided to me for the period of treatment from _____ to _____ for the following purposes:

[ ] For coordination of care
[ ] For processing of my insurance claim
[ ] Other (specify): _____
[ ] For treatment at this facility
[ ] For peer review/third party payer

Information to be furnished (please check all that apply):
[ ] Progress reports throughout treatment
[ ] Report of psychological/psychiatric evaluation
[ ] Continuing Care Plan
[ ] Legal
[ ] Imaging: Results and Impressions
[ ] Neuropsychological Assessment
[ ] Progress Notes
[ ] Consultations
[ ] Other: _____

I understand that the above consent is subject to revocation by me at any time except to the extent that action has been taken in reliance on this consent prior to revocation. The Federal Regulations regarding the confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR part 2) have been explained to me as applicable.

_____ _____
(Patient Signature) (Date)

_____ _____
(Parent/Guardian Signature) (Parent/Guardian Name Print)

_____ _____
(Witness Signature) (Witness Name Print)