SOCIAL CARE SERVICES, LLC

8833 PERIMETER PARK, SUITE 201, JACKSONVILLE, FL 32216

PHONE: 904-294-5329 FAX: 904-485-8460

RELEASE OF INFORMATION

I authorize _____

Address _____

To release: _____

_____

_____

About: _____ _____

Patient Date of Birth

To: _____

Attn: _____

(Name, Title)

For the purpose of: *Continuity of Care*

This consent will expire of the following date, event, or condition: _____

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year. Understand that I may revoke this authorization at any time and will be asked to do so in writing.

I understand these records are protected under Federal and State regulations and cannot be disclosed without my written consent unless otherwise provided for in the Regulations. The individual or agency to which the information is being sent is prevented from redisclosing this information to another party.

I understand that if my records contain information about HIV infection, AIDS or AIDS related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing, this disclosure will include that information.

Signing this authorization allows both parties to share information for the provision of services.

I have the right to inspect and copy the information to be disclosed.

Revoking this consent will have no effect on prior disclosures made before withdrawal of consent.

_____ _____

Signature: Legally Responsible Person Date

_____ _____

Signature: Personnel, Title Date

_____ _____

Signature Authorization Revoked Date