# AUTHORIZATION AND CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

**Directions:**

1. Read this document in its entirety before completing any portion. If you have any questions about the consent, please contact us at 850-222-6341.
2. Indicate the specific records and/or information for which you are providing consent for the holder to release to the FCB for purposes of investigating the ethical complaint.
3. Sign the release in the presence of an adult witness (over 18 years of age). Contact information must be provided for the witness.
4. Make a copy of the release and send the original release to the FCB at the following address:

   Director of Certification
   Attn: Ethics Investigation
   1715 South Gadsden Street
   Tallahassee, Florida 32301

**Statement of Purpose:**

During the course of an ethics investigation, it may be necessary to seek testimony and/or documentation of confidential, protected health information. The purpose of this consent is to allow the Florida Certification Board (FCB) access to relevant records, which may include, but is not limited to medical information; psychiatric, psychological, drug and/or alcohol records; and HIV status.

It is important to understand that access to records is limited to those records specified by the individual providing consent. The FCB will maintain the confidentiality of all records and will only release protected information to members of the standing FCB Ethics Committee and assigned staff members.

FCB will not release protected information to third-parties without express, written consent. A legal parent or guardian may provide consent to protected information regarding his or her child(ren).

**Section 1:**

| | | |
|---|---|---|
| Name | | Date of Birth (mm/dd/yyyy) |
| Street Address | | Home/Cell Phone Number |
| City | State | Zip Code |
| Employer Name | | E-mail Address |
| Street Address | | Work Phone Number |
| City | State | Zip Code |

**Section 2:**
I am providing consent for:

- ❑ Myself, as identified in Section 1, above.
- ❑ My child. Complete a separate form for each child for whom consent is provided.

| | |
|---|---|
| Name | Date of Birth (mm/dd/yyyy) |

**Section 3:**
I hereby give my permission to the agency specified below to release the specified information and/or documents to the Florida Certification Board in their investigation of an ethical complaint. The following information and/or documents may be released. I understand that this information which may include, but is not limited to medical information; psychiatric, psychological, drug and/or alcohol records; and HIV status.

| | | |
|---|---|---|
| Agency Name | | Telephone Number |
| Street Address | | Web-site Address |
| City | State | Zip Code |

- ❑ Face Sheets _____ initials
- ❑ Discharge Summaries _____ initials
- ❑ Progress Notes _____ initials
- ❑ Psychiatric Assessments _____ initials
- ❑ Psychosocial/Family Assessments _____ initials
- ❑ Nutritional Assessments _____ initials
- ❑ History and Physical Assessments _____ initials
- ❑ All assessments _____ initials
- ❑ Other (specify) _____ initials _____

- ❑ Consultation Reports _____ initials
- ❑ Treatment Plans _____ initials
- ❑ Medication Records _____ initials
- ❑ Lab/Test Results _____ initials
  - ❑ Including HIV*
  - ❑ Excluding HIV*

* checking either box does not indicate whether or not the individual providing consent has undergone HIV testing.

**Section 4:**
Information and/or documentation identified in Section 2, above, may be released to the FCB in the format(s) specified below:
❑ Verbal ❑ Written ❑ Fax ❑ E-mail ❑ Other (specify): _____-

**Section 5:**
This consent is subject to revocation at any time except to the extent that the FCB or its employees or agents have already taken action in reliance to it. I hereby release the FCB, its employees, members of the FCB Ethics Committee and investigation and hearing team, and FCB's agents from any liability which may arise as a result of th use of any information contained in the information and/or documents released to the FCB. This authorization and consent for release of information will expire in 180 days from the date signed. I acknowledge that I have read this authorization and consent for release of information, I understand its contents, and have voluntarily signed it on this date, in the presence of the witness identified herein.

| | |
|---|---|
| | |
| Printed Name | Date |
| Signature | |
| | |
| Witness: Printed Name | Date |
| | ( ) |
| Witness: Signature | Contact Telephone Number |