



Friday, May 3, 2024

Florida Outpatient Release of Information

Inspire Counseling and Support Center/The Transition House, Inc.

Authorization for Release of Confidential Information

I, Michael Slattery hereby authorize Inspire Counseling **insert your name here** and Support Center, The Transition House, Inc. (Inspire/TTHI), to obtain or release information regarding this client from/to the entity listed below. This information may include: medical records, mental health records, substance abuse records, and any other record created as part of my services with Inspire/TTHI.

Please select one or both below:

Obtain

Release

Entity Name:

Florida Department of Corrections

Entity Address:

28402 CR 561
Tavares, FL, 32778

Entity Phone Number:

(352) 742-6242

Client Name

Michael Slattery

Client Date of Birth

Wednesday, June 4, 1986

Information to be Obtained and/or Released

ALL OF THE ABOVE

The purpose of obtaining and/or releasing this information:

ALL OF THE ABOVE

Authorization: I certify that this request has been made freely, voluntarily, and without coercion and that the information given is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt of the Release of Information Unit at the facility housing the records. Re-disclosure of my medical records by those receiving the above-authorized information may be accomplished without my further written authorization and may no longer be protected. Without my expressed revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on (date supplied by client); (3) under the following conditions:

I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. For court ordered clients, this information may

be re-disclosed for open court per conversation between the treatment provider, judge, and attorneys. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Release of Information Expiration:

On the below date:

Date of expiration:

Tuesday, December 31, 2024

Client Social Security Number:

306-06-6331

Client (or legal guardian) Signature

A handwritten signature in black ink, appearing to be 'MWA' with a horizontal line through it.

Date

Friday, May 3, 2024