BEACHES TMS & BRAIN HEALTH BEACHES BEHAVIORAL

ALINA M GALLIANO-PARDO, MD, FAPA, FASAM

4141 SOUTHPOINT DR E • SUITE A

JACKSONVILLE • FLORIDA • 32216

904•853•5867 Beaches TMS

904•853•5900 Beaches Behavioral

Release of Information Form for Multiple Sources

Providing information regarding your family members, friends, and other providers can be helpful in facilitating your care and ensures we are able to provide you with the best possible care. This form is optional and allows you to choose who you would like your informational potentially shared with.

<table>
<tr><td colspan="2">Patient Name:</td><td>DOB:</td><td>Initial each specific consent to release</td></tr>
<tr><td rowspan="3">Family Members or Significant Others</td><td>Name/Relationship</td><td rowspan="6">Purpose:
• To facilitate understanding and support in treatment.
• To aid in diagnosis and continuity of care.

Type of information to be disclosed:
• All medical records ☐
• Progress Notes ☐
• Labs ☐
• Medications ☐
• Evaluations ☐
• Other:
_____
_____</td><td>■ Yes
☐ No
_____
Initial</td></tr>
<tr><td>Name/Relationship</td><td></td></tr>
<tr><td>Name/Relationship</td><td></td></tr>
<tr><td rowspan="2">Mental Health Professionals</td><td>Psychiatrist Phone</td><td rowspan="2">☐ Yes
☐ No
_____
Initial</td></tr>
<tr><td>Therapist Phone</td></tr>
<tr><td rowspan="2">Primary Care Physician</td><td>Name/ Group</td><td rowspan="2">☐ Yes
☐ No
_____
Initial</td></tr>
<tr><td>Phone</td></tr>
<tr><td>Pharmacy</td><td></td><td>☐ Yes
☐ No
_____
Initial</td></tr>
<tr><td rowspan="3">Other Specialists</td><td>Name/ Group/ Phone</td><td rowspan="3">☐ Yes
☐ No
_____
Initial</td></tr>
<tr><td>Name/ Group/ Phone</td></tr>
<tr><td>Name/ Group/ Phone</td></tr>
</table>

I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment, a communicable or venereal disease which may include, but is not limited to , diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus also known as acquired immune deficiency syndrome (AIDS) and/or tuberculosis. I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the or use of my health care information for purposes other than for treatment, payment, and healthcare operations. I understand that the potential exists for health information that is release with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPPA law. I understand that I have the right to revoke this authorization at any time by giving written notice to Beaches Behavioral Office, except to the extent that action has already been taken in reliance on it. I hereby authorize Beaches Behavioral to release/receive information from my medical record including general medical information as well as Acquired Immunodeficiency Syndrome and/or HIV tests, psychiatric, psychological, drug and/or alcohol records in compliance with Florida Statutes 90.503.394.459, 395.017, 396.112, 397.053 and Federal Regulation 42 CFR, Part 2.

Patient Signature/ Guardian _____ Date: