CONSENT TO RELEASE AND EXCHANGE INFORMATION & DATA SHARING AGREEMENT

I, _____, am aware that _____ (hereafter referred to as the Named Agency) is part of a cooperative group of organizations that provide behavioral health treatment services and/or authorize State Funded treatment services. A list of all current Broward Behavioral Health Coalition (BBHC) funded behavioral health treatment providers has been given to me by the named agency. This information will be disclosed for the purposes of referral for behavioral health care, the provision of care, and for the reimbursement for services provided on my behalf.

I agree to allow all members of the BBHC provider network and Concordia Behavioral Health ("Concordia"), to exchange among them the following information: my complete name, date of birth, social security number, gender, race/ethnicity, location of intake, case manager, and treatment site.

In addition, I agree to allow the exchange of any information collected through the assessment process, which may include but is not limited to information about my HIV status, applicable medical records, and service delivery history, including information protected under 42 CFR Part 2, among and between the Named Agency, BBHC, Concordia, and the agency(s) that participate in the provider network - unless you choose specifically to not authorize release to a particular agency - consent to all agencies is granted by this Consent to Release.

I also understand that the network provider's ability to assess and access treatment, payment, enrollment, and/or eligibility for benefits is dependent on whether I sign this form. Refusal to sign consent will not prevent receiving services at a provider member, but may limit referral and/or access into another agency.

I fully understand the provisions of this Consent to Release, my rights to the confidentiality of my records, and I also understand that no other information regarding my treatment program, whereabouts, or any other factor will be released without my express and written consent.

This Consent to Release may be revoked at any time by signing the revocation line below, or by informing the agency holding this original form in writing, except to the extent that action had been taken in reliance thereon, (any information already released cannot be revoked). This Consent to Release shall expire in twelve (12) months from the date of execution below. I understand that any entity receiving information as a result of this release is bound by the following statement and that this Consent to Release shall become part of my record.

ACKNOWLEDGEMENT OF REQUIRED INFORMATION

I have been informed by _____ that the following may be requested for admission into any of the agency(ies) that participate in the provider network (Provider network agencies listed on attachment I): Detoxification Clearances, Medical Clearances, Prescribed Medications, Psychiatric Clearances and/or Evaluations

This is information and/or medication requirements must be provided and/or arranged prior to admission into the provider network agencies. Failure to meet these requirements will delay admission process.

_____ _____
Agency Representative Date

_____ _____
Client Signature Date

_____ _____
Parent, Guardian, or Authorized Representative Date

☐ I wish to revoke this release of information, and I understand that I am entitled to a copy of this form.

_____ _____
Client Signature Date