FLORIDA MIND HEALTH Center

4408 NW 36 Ave
Gainesville, FL 32606
(352) 448-6062

CONSENTS AND AUTHORIZATIONS

Patient Name: _____

Authorization for Release of Information

I hereby authorize Florida Mind Health Center to obtain from any source and examine and use or discuss and disclose and provide any information necessary regarding the patient with health care practitioners involved in the care of the patient. These communications of information may involve unencrypted electronic communications by email, phone, text messages, and voicemail as well as fax. These communications may include protected health information and other confidential information. This authorization to obtain and release information is valid until revoked. The undersigned may revoke this consent in writing at any time, except with regard to information that has already been shared or disclosures that have already been made in reliance on such consent.

Electronic Communications Authorization

I hereby authorize Florida Mind Health Center to communicate with me using electronic communications including email, text messages, and voicemail. I may be contacted using the numbers or addresses that I have provided to Florida Mind Health Center, or that I have used to initiate contact with Florida Mind Health Center. These communications may include appointment information, as well as protected health information and confidential information. I understand that these electronic communications are not encrypted.

Acknowledgment of Privacy Practices Notice

I have reviewed the Notice of Privacy Practices at https://www.FLmindhealthcenter.com/privacy-policy. I acknowledge that a copy of the Privacy Policy is available to me upon request.

Financial & Appointment Policies/Agreement to Pay

I have reviewed and agree to the Florida Mind Health Center's policies regarding appointment scheduling and payment at https://www.FLmindhealthcenter.com/financial-policy. I acknowledge that a copy of the Financial & Appointment Policy is available to me upon request.

I understand that I am directly responsible for all charges incurred for medical services for the patient.

With my signature, I understand and agree to Florida Mind Health Center's above patient policies.

_____
Signature

_____ _____/_____/_____
First name Last name Date