Blue Umbrella Psychiatry
6100 Griffin Rd. 2nd Floor
Davie, FL - 33314-4416

**2027 Comprehensive Release of Information

Blue Umbrella Psychiatry
Authorization to Release, Obtain, and Exchange Confidential Information
6100 Griffin Rd. 2nd Floor, Davie, FL 33314

Phone Number: (954) 341-5215
Fax Number: (954) 613 - 9047

This document gives Blue Umbrella Psychiatry permission to communicate with someone on your behalf about your healthcare and conditions.

Authorization to Release and Obtain Confidential Records and Information

A. Identifying information about me/the patient

Name of Patient *

Date of Birth *

Current Phone Number *

B .Authorized Healthcare Providers and Organizations
I authorize Blue Umbrella Psychiatry, including my treating providers and authorized staff, to obtain, release, and exchange confidential information with the providers, facilities, schools, or organizations I identify and select below.
Please complete only the sections that apply. You may authorize more than one provider or organization.

(1) Primary Care Provider (PCP) I authorize communication with my Primary Care Provider. * ☐ Yes ☐ No

Provider/Practice Name:

Phone:

Fax:

(2) Psychiatric Provider (Current or Previous) I authorize communication with my current or previous psychiatric provider. *

☐ Yes ☐ No

Provider/Practice Name: _____

Phone: _____

Fax: _____

(3) Therapist or Mental Health Provider (Current or Previous) I authorize communication with my current or previous therapist or mental health provider. *

☐ Yes ☐ No

Provider/Practice Name: _____

Phone _____

Fax: _____

(4) School or Educational Institution I authorize communication with the school or educational personnel identified below. *

☐ Yes ☐ No

School Name _____

Contact Person/Department _____

Phone _____

Fax _____

(5) Other Medical Specialist or Healthcare Provider I authorize communication with the following specialist or healthcare provider. *

☐ Yes ☐ No

Provider/Specialty _____

Practice/Facility _____

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Phone _____

Fax: _____

(6) Hospital, Treatment Facility, or Other Organization I authorize communication with the following facility or organization. * ☐ Yes ☐ No

Facility/Organization Name: _____

Contact Person/Department: _____

Phone: _____

Fax: _____

(7) Additional Provider or Organization * ☐ Yes ☐ No

Name _____

Specialty/Organization: _____

Phone: _____

Fax: _____

Only the providers, schools, facilities, and organizations specifically identified and selected above are authorized under Section B.

C. Information Authorized for Release or Exchange

I authorize Blue Umbrella Psychiatry to obtain, release, and exchange the following information with the providers and organizations identified in Section B for the purposes described in this authorization.
Please select Yes or No for each category.

Previous treatment history * ☐ Yes ☐ No

Medication history * ☐ Yes ☐ No

Previous health assessments * ☐ Yes ☐ No

Treatment records from Blue Umbrella Psychiatry, including psychiatric care, psychotherapy encounter and progress notes, treatment summaries, TMS, ketamine, and other services received *	☐ Yes ☐ No
Assessments, diagnoses, prognoses, and treatment recommendations *	☐ Yes ☐ No
Social, family, and developmental histories *	☐ Yes ☐ No
Other medical and behavioral health records reasonably necessary for treatment, coordination of care, or patient safety *	☐ Yes ☐ No
Authorize All: I authorize the release and exchange of all seven categories listed above. *	☐ Yes ☐ No

Additional Restrictions (Optional)
These information selections apply to all recipients identified in Section B unless I specify additional restrictions.
For a recipient requiring different information permissions, I understand that a separate authorization may be needed.

D. Authorized Personal Contact

I may designate one trusted individual, such as a spouse, parent, adult child, caregiver, or another person of my choosing, with whom Blue Umbrella Psychiatry may communicate regarding my care.

I may designate one trusted individual, such as a spouse, parent, adult child, caregiver, or another person of my choosing, with whom Blue Umbrella Psychiatry may communicate regarding my care.	☐ I wish to authorize a personal contact.	☐ I do not wish to authorize a personal contact.
Authorized Contact Full Name	_____	

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Relationship to Patient: _____

Phone Number: _____

Information I Authorize Blue Umbrella Psychiatry to Share Please select all that apply:

- ☐ Appointment scheduling, confirmations, and general administrative matters.
- ☐ Billing, insurance, and financial information.
- ☐ Medication information and coordination.
- ☐ Diagnoses, treatment plans, and general treatment updates.
- ☐ Medical and psychiatric treatment information and records, including regular psychotherapy encounter and progress notes.
- ☐ All of the above.

Additional Restrictions (Optional):

I understand that Blue Umbrella Psychiatry may communicate with my designated personal contact only within the permissions selected above and as otherwise permitted or required by law.

I understand that designating this individual does not automatically give them legal authority to make healthcare decisions on my behalf.

I may change or revoke this authorization in writing.

E. Purpose of Release and Exchange

I authorize the release and exchange of information for the following purposes, as applicable:

1. Further medical or mental health evaluation, treatment, or care.

2. Treatment planning and continuity of care.

3. Medication management and coordination.

4. Qualification for services or benefits.

5. General coordination of care.

6. Educational support, accommodations, and recommendations, when applicable.

7. Communication with my designated personal contact within the permissions selected above.

F. Methods of Communication

I authorize Blue Umbrella Psychiatry to communicate with the individuals and organizations identified in this form through appropriate methods, including:

- Telephone
- Email or secure electronic communication
- Text messaging
- Fax
- Written correspondence
- Video communication
- In-person discussions

I understand that Blue Umbrella Psychiatry will use reasonable safeguards to protect confidential information in accordance with applicable privacy laws and practice policies.

G. Release of Records and Treatment Summaries

I understand that Blue Umbrella Psychiatry may provide treatment summaries or relevant clinical records, including psychotherapy encounter and progress notes, when authorized and appropriate for treatment, continuity of care, or other purposes identified in this form.

A treatment summary may include relevant diagnoses, treatment history, medications, treatment progress, clinical recommendations, and other information appropriate to the request.

Blue Umbrella Psychiatry may provide a treatment summary when it adequately addresses a request. Requests for additional or complete clinical records will be reviewed and fulfilled as required or permitted by applicable federal and state laws.

I understand that an outside provider or organization may submit a separate authorization signed by me or my legally authorized representative. Blue Umbrella Psychiatry may process that authorization according to its terms and applicable law.

This authorization does not limit disclosures otherwise permitted or required by law. Records subject to special confidentiality requirements will be handled according to those requirements.

H. Duration and Expiration of Authorization

This authorization will remain effective throughout my treatment relationship with Blue Umbrella Psychiatry and will expire upon termination of that relationship, unless I revoke it

earlier in writing or applicable law requires otherwise.
I understand that this authorization does not automatically expire after one year and does not require annual renewal solely because a new calendar year begins.
I may update my authorized providers, organizations, personal contact, or disclosure preferences by completing a revised authorization.
I may revoke this authorization at any time by submitting a written request to Blue Umbrella Psychiatry. Revocation will not affect disclosures already made in reliance on this authorization.
I. Patient Rights and Confidentiality
I understand and acknowledge that:
1. This authorization is voluntary. I may choose which providers, organizations, and personal contacts I authorize.

2. Refusing to sign this authorization will not affect my eligibility for treatment, payment, enrollment, or benefits, except where permitted by law.

3. I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it.

4. I have the right to receive a copy of this signed authorization.

5. Information disclosed to an authorized recipient may be redisclosed and may no longer receive the same privacy protections, depending on the recipient and applicable law.

6. Certain specially protected records may require additional authorization or legal review before disclosure.

7. For minor patients, parental or guardian access and disclosure permissions remain subject to applicable federal and Florida confidentiality laws.

8. Designating a personal contact does not grant that individual legal authority to make medical decisions on my behalf.

J. Patient Acknowledgment and Authorization
I acknowledge that I have read and understand this Authorization to Release, Obtain, and Exchange Confidential Information.
I understand that I may identify the healthcare providers, schools, organizations, and personal contacts with whom Blue Umbrella Psychiatry may communicate.
I understand that the information released under this authorization will be limited to the

categories I have approved, subject to my stated restrictions and applicable law.

I understand that I may update or revoke this authorization as described above. Authorization Preference *	☐ I authorize Blue Umbrella Psychiatry to obtain, release, and exchange information as selected in this form. ☐ I decline to authorize any additional release or exchange of information through this form at this time.

By signing below, I confirm my selections and voluntarily authorize the disclosures described in this document.

Patient or Legal Representative Name: *

Patient or Legal Representative Signature: *

Date: *

If signed by a parent, guardian, or legal representative:

Relationship to Patient:

Description of Legal Authority: