AUTHORIZATION FOR RELEASE OF INFORMATION
FROM LEE MEMORIAL HEALTH SYSTEM

Client Services Network of Lee County ("CSN") is a shared client information and referral system administered by the Lee County Department of Human Resources ("DHS"). In order to improve the services and programs available to you and others at the Triage Center / Low Demand Shelter, CSN collects and analyzes information from its affiliated agencies. Lee Memorial Health System ("LMHS") is affiliated with the CSN. Additional affiliated agencies of CSN include the Lee Mental Health Center, Southwest Florida Addiction Services, and The Salvation Army. In order for LMHS to share protected health information with CSN, LMHS requires CSN to provide a release from its clients.

Authorization: I, _____ (print name), understand and acknowledge that LMHS is seeking my permission to disclose information to the CSN. I hereby authorize the use or disclosure of my protected health information as described below to the CSN. I understand that this authorization is voluntary and I may refuse to sign it.

□ All Medical Records
□ Emergency Room Records Only
□ Other (Please Specify):_____

The purpose of this release is to allow LMHS to provide the records to the CSN, so that CSN can monitor the outcomes of the services provided to you, assist in the planning and delivery of services to you, analyze the utilization of entities affiliated with the CSN, review the efficacy and benefits of the Triage Center / Low Demand Shelter, review and analyze demographic trends and service patterns of the CSN affiliated entities, review and analyze the usage relationships between entities affiliated with the CSN, review and monitor client encounters with the CSN affiliated entities and assist in improving the overall quality of care and services for individuals and families in Lee County.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed pursuant to this authorization.

I further understand that I will not be denied services at the Triage Center /Low Demand Shelter or LMHS based on whether I sign this authorization.

Expiration: If the protected health information to be disclosed contains HIV/AIDS or drug and alcohol abuse treatment records, this authorization expires in 60 days. Otherwise, you may select either of the following expiration events:

□ 1 year from the date in which I, or my legal representative, signs this authorization;
□ Upon release of the above records.
□ Other (Please Specify): _____

Right to Revoke: I may revoke this authorization at any time by providing written notice to the Privacy Officer at 2776 Cleveland Avenue, Ft. Myers, Florida 33901. My revocation will be effective upon receipt, but will not have any effect on prior actions taken in reliance upon this authorization.

Redisclosure: I understand that information disclosed pursuant to this authorization could be re-disclosed by CSN and no longer protected by the Health Insurance Portability and Accountability Act ("HIPAA").

_____ _____
Signature of Client Date

If signed by the Client's legal representative:
Printed Name of representative: _____

Relationship to the Client: _____