THE GULF COAST CENTER
AUTHORIZATION FOR MUTUAL EXCHANGE OF VERBAL INFORMATION

This authorization may not be used to release or obtain documented information (For release documented information use Form #9020)

Client's Full Legal Name	Date of Birth	Social Security Number	Consent Effective Until

I authorize _____ (program name) to give and receive verbal information to the individual(s) listed below for the purpose of obtaining personal/medical information related to my care and treatment at The Gulf Coast Center. I understand that the verbal information to be disclosed may include mental health information, mental retardation information, drug/alcohol (substance) information, and/or HIV/AIDS information, as authorized below. I understand that I may revoke or cancel this authorization in writing at any time, with the exception that action has already been taken. The program listed above must receive my written revocation or cancellation before it is considered effective. This authorization will remain in effect for 90 days or the time period specified above. I understand that the program releasing or obtaining this verbal information is free from all legal liabilities that may arise from this act. I understand that I have the right to limit the verbal information to be released.

I understand that I have the right to refuse this authorization. The Gulf Coast Center will not withhold treatment, Medicaid benefits, or payment processing if I refuse to sign this authorization. However, I will be required to sign this authorization form before being provided treatment if the treatment is alcohol or drug abuse treatment and the purpose of the authorization is to obtain payment for the alcohol and drug abuse treatment; or the treatment is research-related and the purpose of the authorization is to obtain permission to use and disclose protected health information for such research.

I understand that I am entitled to receive a copy of this authorization. I want and have received a copy of such: __ Yes __ No

I request that the following information NOT be released to the individuals listed below:

_____

I authorize the program listed above to release the following information to the individuals listed below (check all that apply):

- ❑ MENTAL HEALTH INFORMATION
- ❑ MENTAL RETARDATION INFORMATION
- ❑ ALCOHOL/DRUG (SUBSTANCE) INFORMATION
- ❑ HIV/AIDS INFORMATION

INFORMATION MAY BE RELEASED TO THE FOLLOWING:

NAME	RELATIONSHIP	TELEPHONE NUMBER

CLIENT/PARENT/LEGALLY AUTHORIZED REPRESENTATIVE SIGNATURE	DATE
WITNESS SIGNATURE (Staff Signature/Title)	DATE
WITNESS SIGNATURE* (Staff Signature/Title)	DATE

REVOKE OF CONSENT

(Do not complete until Revoke or Cancellation of Consent has been requested. Must be signed by client/parent/legal representative before it is effective)

I, _____, hereby revoke or cancel this authorization effective _____ (date).

CLIENT/PARENT/LEGALLY AUTHORIZED REPRESENTATIVE SIGNATURE	DATE
WITNESS SIGNATURE (Staff Signature/Title)	DATE
WITNESS SIGNATURE* (Staff Signature/Title)	DATE

*Two witness signatures are required when an individual is his or her own legal guardian and signs his or her name with an "X" or an indescribable mark.

GCC #9068 (Rev. 3/03)

A photocopy or facsimile of this authorization is as valid as the original.

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