A1 MEDICAL & BEHAVIORAL HEALTH, LLC

Consent for Behavioral Health Treatment

I hereby give my consent to receive psychiatric care, psychological assessment, and/or psychotherapy from the professional staff employed by ***A1 Medical & Behavioral Health, LLC***.

I, _____, hereby authorize you to release any and all medical or confidential information contained in the record of:

Name: _____ Date of Birth: _____

To be released to A1 Medical & Behavioral Health, LLC. This authorization does not expire unless indicated.

I further approve contact with my primary physician of family members and appropriate community staff, including but not limited to the Director of Nursing, Director of Social Services, Care Plan Coordinator and/or their designated agents for medical or claims management purposes.

I understand and agree that my disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information or under certain other conditions as prescribed by law. I understand that confidential and privileged information may be released without my consent or authorization under circumstances recognized by Florida law and HIPAA.

I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents, any information needed to determine these benefits or the benefits payable for related services.

I hold the above referenced provider and A1 MEDICAL & BEHAVIORAL HEALTH, LLC harmless against any and all claims arising from the release of Protected Health Information as permitted by law. I understand that I may revoke this consent at any time except to the extent that the provider has taken action and reliance on this consent.

Please refer to the notice of privacy practices for protected health information ("Privacy Notice") for a more complete description of the uses and disclosures that the provider may use of your protected health information. You have the right to review the Privacy Notice prior to signing this consent.

_____ _____

Signature of Resident or Responsible Party Date