AUTHORIZATION TO RELEASE AND/OR OBTAIN INFORMATION

(1) CLIENT NAME _____(2) DATE OF BIRTH_____

This will authorize (3)_____
NAME OF THERAPIST
to (4)____release to and/or ____obtain information from:

(5)_____
(NAME OF INDIVIDUAL, HOSPITAL, OR AGENCY WHO WILL RECEIVE/RELEASE INFORMATION)

_____
(ADDRESS)

_____
(PHONE NUMBER, FAX NUMBER, E- MAIL ADDRESS)

(6) Information to be released includes (Please INITIAL each item to be released):

_____ ALL INFORMATION including medical, psychiatric, psychological, HIV/AIDS, alcohol, drug or other substances.

_____ Specific information/reports, such as: (Please INITIAL each item to be released)

____ Treatment/Discharge summary ____ Physical/laboratory results

____ Clinical/psychiatric/psychological assessment ____ Progress Notes

_____ Verbal exchange of information. Please specify: _____

_____ Other:_____

(7) Specific purpose for disclosure of information:_____

This information has been disclosed from records whose confidentiality is protected by Florida Statutes and federal regulations governing confidentiality (42 CFR Part 2). This information cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time (except to the extent that action has been taken) by written notification to the Therapist named at (3) above. If I DO NOT revoke this authorization, it will expire automatically in 365 days.

(8)_____ (9)_____
Signature of Client DATE

_____ _____
Signature of empowered representative DATE

(10_____ _____
Signature of Witness