THE COUNSELING & FAMILY WELLNESS CENTER
1385 W. SR-434 SUITE 207 LONGWOOD, FL 32750

Authorization for Release

Authorization for Release for the use or Disclosure of Confidential Mental Health Information

Client Name: _____ Client DOB: _____

Address: _____ Date of Request: _____

Effective dates of Release: From _____ to _____

As required by the National Privacy Regulations (HIPPA) I,

_____

hereby authorize this office, The Counseling & Family Wellness Center, represented by the Counselor _____ to use or disclose medical and/or psychiatric information of the client listed above to:

(Name of individual or agency) _____

(Address) _____

Information to be disclosed: _____

I understand that the specific reports disclosed would include:

_____

_____

(Describe specifically)

I understand that the information disclosed above may be re-disclosed to other parties without the knowledge or consent of this office and acknowledge that once disclosure occurs the information is no longer protected.

I understand that I can revoke consent with written notice, except to the extent that action has been taken in reliance upon this authorization, and that I have a right to review all information before it is disclosed. I understand that if I do not sign this document, it will not condition my treatment or payment.

_____ _____

Signature of Client or Parent/Legal Guardian Date of Authorization

_____ _____

Signature of Witness Printed Name of Witness