Family Psychology Associates

Strengthening relationships...improving lives.

Authorization for Release of Information

The undersigned hereby authorizes Family Psychology Associates to receive or release the below listed information to or from the following named agency or physician:

Family Psychology Associates
Attention:_______________________________
801 2nd Street North Suite 7
Safety Harbor, FL 34695

AND ____

____

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____

INFORMATION:

___ Medical
___ Educational
___ Social History
___ Any and all information regarding treatment
___ Intellectual
___ Psychological Evaluation
___ Psychiatric Evaluation

PATIENT:

Name:____ Birth Date: ______________________________

Address:____

City:_______________________________ State: ____________ Zip Code: ______________________________

The undersigned authorized the release of information for the following purpose:

____

I understand that the information released by other professional to Family Psychology Associates will be protected as private data according to the provisions of state and federal laws and, to the extent permitted by law, will not be released without my authorization. This does not mean that these materials will be protected from subpoena power.

I recognize that Family Psychology Associates cannot guarantee the privacy of information released, but it is my intent that the party I designate to receive it will consider it private according to the provisions of state and federal laws. Further, I understand that I may rescind this authorization at any time by giving written notification to the above-named parties and otherwise it will expire one year from this date.

My authorization is given freely and with competence and adequate understanding of purpose.

____ ____

Patient's Signature Witness

____ ____

Legal Guardian, if minor Date