AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: ____ Date: _______________

Attention: Family Psychology Associates

Provider: ___________________________

801 2nd St. N. Ste 7, Safety Harbor, FL 34695

Phone Number: 727 725 8820

Fax Number: 727 725 8361

I authorize release of information to or from:

____

Address: ____________________________

City: _________________________________

State: ______________ Zip: ________________

Phone Number: ___________________________

Fax Number: ____________________________

FOR THE PURPOSE OF: ____

Release the following portion(s) of patient's medical record:

___ Medical

___ Intellectual

___ Educational

___ Psychological Evaluation

___ Social History

___ Psychiatric Evaluation

___ Any and all information regarding treatment

I understand that the information released by other professionals 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 (Or Legal Guardian) Witness

Address: ______________________________

City: _________________________________

State: ______________ Zip: ______________

Patient Date of Birth: ____________________