PHONE: 321.259.1662
FAX: 321.779.7729

AUTHORIZATION CONSENTING TO RELEASE OF INFORMATION

RE: ________________________________ S.S. # ______ /____ /_______ D.O.B. _____/_____/_____

I authorize the Florida Counseling Centers to discuss (verbally or in writing) any information that has been brought up during psychotherapy with the person(s) or staff of clinic, office, agency, or institution(s) named below and to receive any relevant information from the person(s) named below.

1. Name ____
2. Address ____
3. Phone Number ____
4. Fax Number ____
5. Email Address ____

For the following reason(s): ____

____

I understand that this release of information is intended to allow me to provide my informed consent for an exception to my confidentiality and the protection of my privacy guaranteed under Federal Law, including but not limited to the Privacy Act of 1974 (P.L. 93-579). I understand that the Florida Counseling Centers cannot be responsible for the protection of my privacy once the contents of my records are released or for the use of the information once it is conveyed, and I release the Florida Counseling Centers from all liability arising from this release. I understand the person receiving this information is prohibited from making any further disclosure of it without my written consent. This consent may be revoked by me at any time. This consent is in effect only for three years from the date of the last session, unless revoked earlier or renewed.

Signature: ____ Date: ______________

Guardian Signature: ____________________________________ Date: ______________

Witness: ____ Date: ______________

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