

Authorization for Release of Information



Client Name: Write the client's full legal name

Address: Write the address of your current residence

Phone: Write your current phone number

_____ I authorize my counselor to release and/or obtain information from:
(Initial here)

Name of person and/or organization: Write the name of the person you are permitting us to communicate with

Address: Write this person's address

Phone/Fax: Write this person's phone number

Email address: Write this person's email address

I authorize information to be released by the following methods of communication:

_____ Phone _____ Fax _____ Email _____ Mail
(Initial here) (Initial here) (Initial here) (Initial here)

The information to be released is regarding: Write what you are requesting that we tell this person or what information we should get from this person. Examples include "Counselor's assessment, diagnosis, and treatment plan," or "Medication prescribed by doctor," or "Records from doctor's visit on September 10, 2019."

I understand that:

- I do not have to sign this authorization and my refusal to sign will not affect my ability to obtain treatment.
- I may revoke this authorization at any time by submitting a written request to my counselor.
- This authorization will expire on: Write a date one year from now unless you want this permission to expire sooner

I certify that this form has been fully explained to me and that I understand its contents.

Client Signature: All clients, even children, should sign _____ Date: _____

Parent/Guardian Signature: Required if client is under 18 _____ Date: _____

Counselor: _____ Date: _____

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