Tracey C. Kavanagh, M.A., L.M.H.C.
Licensed Mental Health Counselor
1000 Riverside Avenue Suite 312
Jacksonville, Florida 32204
Phone (904) 318-2258
Fax: (904) 808-1472
Email:tckava55@gmail.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____ authorize _____,

on ____/____/_____ to obtain and release information and records pertaining to my evaluation and treatment, for purpose of providing records or information to _____(organization or person) for purposes of _____.

_____This is a single disclosure. _____This is a disclosure for 90 days.

Date disclosure signed ____/____/_____.Date disclosure expires____/____/_____.

_____Check here if this authorization allows for VERBAL exchange only.

_____Check here if this authorization allows for exchange of medical records.

I hereby release the above named practitioner from liability which may arise as a result of the information contained in the records released:

Signature of Client:_____Date:_____

Printed name of Client:_____Date:_____

Signature of Guardian:_____Date:_____

Printed name of Guardian:_____Date:_____

Signature of Witness:_____Date:_____

Printed name of Witness:_____Date:_____