Susan Posada, PhD, LMHC, LMFT
Phone: (813) 215-5558

110 W. Country Club Dr
Tampa, Florida 33612

RE: _____ **DOB:** _____ **SSN:** _____

AUTHORIZATION TO RELEASE, RECEIVE, OR EXCHANGE INFORMATION

Your records, which are property of Susan Morhard Posada, PhD., are privileged and confidential. A signed authorization to release or exchange psychiatric and/or psychological information is valid according to Florida Statutes 394.4615, 490.0147, 397.501, 90.503, 381.004, 394.459 and Federal Regulation 42 CFR, Part 2.; 45 CFR 160-164. Your records will not be released without this waiver except under the following circumstances: In the event of a valid emergency, upon receipt of a Court Order, allegations of elder or child abuse, or upon receipt of a request which may be governed by other Florida Statutes, such as Worker's Compensation, etc. When exchanging information in cases where the client is involved in treatment with other agencies or professionals this authorization may include verbal as wells as written communication (to include clinical records).

CIRCLE ONE:

I authorize Susan Posada, PhD to: EXCHANGE WITH: RECEIVE FROM: RELEASE TO:

(NAME) _____ (PHONE NUMBER) _____

(ADDRESS) _____ (CITY/STATE) _____ (ZIP) _____

THE FOLLOWING INFORMATION: ( ) Psychiatric/Psychological Workups

( ) Discharge Summary ( ) HIV/AIDS Records ( ) Legal ( ) Alcohol/Drug Abuse

( ) Educational/IEP ( ) History & Physical

( ) Other (Please specify): _____

FOR THE PURPOSE OF: ( ) Treatment Planning ( ) Information for Physician

( ) Information for Attorney ( ) Personal Use ( ) Continuity of Care

( ) Other (Please specify): _____

I have given my consent freely, voluntarily, and without coercion. Re-disclosure of this information without further written information is prohibited by Federal Regulations, which provide for penalties if violated.

This consent will expire upon satisfaction of the need for disclosure; and 90 days past the end of treatment when Exchanging Information; and not to exceed 1 year after the date signed for Release of Information. I may revoke this authorization at any time providing I notify Susan Morhard Posada, PhD, PA, in writing to that effect. However, such revocation will have no effect on any action previously taken.

PRINT NAME: _____

CLIENT SIGNATURE: _____ DATE: _____

PARENT/LEGAL GUARDIAN SIGNATURE: _____ DATE: _____