Counseling Associates of Lake Mary

Individual, Family, & Couples Counseling

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: ___________________________________ Date of Birth: _____________________

I, _______________________________, hereby authorize the Center for Psychiatry and Behavioral Health, LLC to (check one) _________ *Obtain* and/or _________ *Release* my medical, psychiatric, alcohol, drugs, and/or HIV testing, ARC and AIDS diagnosis information contained in my records or disclose information (check one) ________ *to* / ________ *from*:

Name of Office/Doctor: ____

Address: ____

____

Phone #: _______________________________ Fax #: _______________________________

FOR THE PURPOSE OF:

____ Continuation of Treatment ____ Coordination of Care ____ Application for Insurance

____ Legal ____ My Own Personal Records (TX Letter)

____ Other (Please specify) ____

____

____ _________________________
Patient/Legal Representative Signature Date

____ _________________________
Office Staff Name Date

******This Authorization Form is valid only for 1 (ONE) year**