Psychology Associates of Brevard

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Consent for Release of Confidential Information

I, _____ hereby grant _____ permission to

Check all that apply:

( ) speak to the person/organization listed below
( ) release my records to the person/organization listed below
( ) release my child's records to the person/organization listed below
( ) request records from the person/organization listed below
( ) write a letter person/organization listed below

Person/organization authorized to release information to/from:

Name: _____ **Phone:** _____

Address: _____ **Fax:** _____

_____

Records/information will include medical/psychological, behavioral, alcohol, and/or drug abuse information and/or school records.

Patient Name: _____

Date of Birth: _____

Soc.Sec.No.: _____

Purpose of releasing this information:

_____

_____

I understand that my records are protected under the Federal Confidentiality Regulations as well as Florida State Law. My records cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time by so informing the above-named parties in writing. However, such written revocation will have no effect on actions taken prior to the revocation. If I do not revoke this release, it will expire one year after I terminate with the above-named party.

_____ _____ _____
Signature of patient/guardian Relationship to patient Date

_____ _____
Witness Date