Smith & Associates Mental Health

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Authorization for Release of Information and Records

Patient's Name: _________________________________ Date: _________

I have been informed that under Florida law, communications between a patient and his/her mental health professional are privileged and may not be disclosed by the treating provider without the patient's consent. I also have been informed that patient records maintained by a mental health service provider may not be disclosed to third parties except with the patient's consent or through legal process.

I hereby authorize _______________________________________ , Mental Health Provider to disclose, release and/or obtain records to/from:

____My primary care physician, Dr.

____ My Psychiatrist, Dr.

____ My previous Mental Health

____ School Officials

____ Other

This authorization is only for the limited purpose of releasing information to and discussing my case with those individuals and companies for purpose of evaluation and treatment. This authorization shall remain in effect until revoked by me in writing.

____ __________________

Patient/Guardian Signature Date