Laura Durant, LMHC, Inc.
Phone: (561)271-8120
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AUTHORIZATION TO:

_____ RELEASE INFORMATION

_____ REQUEST INFORMATION

Patient Name: _____D.O.B._____ SS# _____

I give Laura Durant, LMHC, LLC permission to obtain and/ or release Information/Records

From/With/To:_____

Address:_____

Phone:_____ Fax:_____

Reasons for Disclosure:_____ Treatment Planning:_____ Preparation of Report

The following information may be released:

Medical Evaluation and treatment
Psychiatric Evaluation and treatments
Lab Results
Medication History
Progress Notes
Billing Information
Substance Abuse Diagnosis and Treatment
Discharge Summary
Other:_____

I understand that this authorization release my general medical information as well as information concerning my psychiatric/substance abuse treatment, test results of AIDS, HIV, and related conditions.
Cancellation of my consent will occur automatically one year after the date of the consent below, I also unhesitant that I have the right to revoke my consent at any time by delivery of written notice to my psychiatrist or therapist. Cancellation will be effective not he date of the notice received by the office but will exclude information already furnished before the date of receipt of cancellation.
To recipient of information: This information is release to you from records whose confidentiality is protected by federal law and regulations. Florida Statues prohibits you from making any further disclosures of it without written consent or as otherwise permitted by law.

_____ _____
Signature of patient or legal representative Date

_____ _____
Witness. Date