RELEASE OF CONFIDENTIAL INFORMATION

5/06

I _____
Name Address

authorize Lisa A. Smith ,2180 N. Park Ave., Winter Park, Fl. 32789, 407-629-6448 to disclose

to _____
Name/Agency Address

information about _____, birth date_____ for the following purpose:

☐ further treatment ☐ treatment planning & managed care/insurance benefits.

These records concern the time between _____and_____.

I understand that my records are protected under Federal (42CFR Part 2) and/or State Confidentiality Regulations. This authorization may be withdrawn at any time in writing except to the extent that the program or person which is to make this disclosure has acted in reliance on it. Upon revocation of authorization, further release of information shall cease immediately. File copy is considered equivalent to the original. This release of information expires in 6 months. I hereby release Lisa Smith from any and all liability arising there from. I have read and received a copy of this release. I consent of my own free will.

_____
Signature Print Date

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations 42 CFR Part 2 prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Dear Dr. _____,

Your patient, _____was seen by Lisa A. Smith, M.Ed., L.M.H.C., L.M.F.T., N.C.C.
Date of initial assessment_____next appointment _____
Diagnosis or presenting problem_____Treatment recommendations_____

Please call if further information would be helpful.

Sincerely,

Lisa A. Smith, M.Ed., L.M.H.C., L.M.F.T., N.C.C.