###### 5pPositive Counseling

###### Rhoda Donnelly, LCSW

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# AUTHORIZATION TO RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION

***Only to be completed if you would like your therapist to share your health information with someone other than you.***

***TO BE VALID THIS FORM MUST BE FILLED OUT COMPLETELY***

***CLIENT NAME:***

***SOCIAL SECURITY #: DOB:***

***ADDRESS: PHONE***

This will authorize Rhoda Donnelly, LCSW to release information from my record in accordance with Florida Statutes 394 .459(9), 381.609 (2)(F), 395.3025, 90.503, 458.21 396.112, 397.053, 455.241, 490.32. 90.42, 491.0147 and Federal Law CFR II.

The release of any information concerning AIDS, Human Immuno-deficiency Virus Infection, ARC, AIDS-Related Complex and the performance of any tests, counseling, and the results and treatment thereof are also authorized. I understand that my records have a privileged and confidential status. I am waiving that status for the purpose contained within this authorization.

***INFORMATION REQUESTED:***

***Biopsychosocial Assessment***  ***Treatment Plan***

***Progress Notes***\_\_\_\_\_\_\_ *C****losing Summary***

***\_\_\_\_\_\_\_ Other*** (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Information is***  ***To Be Released To or***  ***Obtained From: (enter Name of individual to whom this Release is directed)***

***For Purpose of:***

A general medical authorization and subpoena duces tecum without a specific authorization to release information MUST have this waiver from the patient or his empowered representative.

I UNDERSTAND that I have the right to refuse to sign this authorization.

I FURTHER UNDERSTAND that I am authorizing the release of information from records whose confidentiality and privileged status is protected by Federal Regulations and Florida Statutes, and that any re-disclosure of this information by the receiving agency is prohibited.

***This authorization is for*** a  single disclosure, valid for up to 90 days from date of my signature DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_or

continuing disclosure, valid for one hundred eighty (180) days after date of my signature as it appears below. This authorization may be revoked at any time upon written notification by the signatory or Client, but revocation has no effect on action previously taken.

X

Signature of Client (If client is minor child, parent must also sign) Date

Signature of Parent or Legal Guardian (if client is minor) Date

Signature of Witness Date