RELEASE OF INFORMATION

REQUEST AND AUTHORIZE:

Fern Creek Counseling
Elizabeth Kunz, LCSW
2475 Alome Avenue Winter
Park, Florida 32792

TO RELEASE INFORMATION TO AND FROM: (NAME/ADDRESS OF AGENCY, OFFICE OR PERSON)

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REGARDING PATIENT: ________________________DATE OF BIRTH_______
ADDRESS: ____
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THE INFORMATION TO BE RELEASED FOR A PERIOD OF 12 MONTHS FROM THE DATE SIGNED.

I AUTHORIZE THE ABOVE NAMED AGENCY(S), PERSON, OR OFFICES TO EXCHANGE VERBAL (TELEPHONE) AND WRITTEN INFORMATION. AS SPECIFIED ABOVE FOR THE PURPOSE AND TREATMENT PERIOD INDICATED. I HOLD HARMLESS FERN CREEK COUNSELING IN REGARD TO THE USE OF INFORMATION AUTHORIZED FOR RELEASE OF EXCHANGE. I UNDERSTAND THAT THIS FORM IS NOT REQURIED AS A CONDITION FOR TREATMENT AND THAT IT MAY BE REVOKED BY ME IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN. IN THE ABSENCE OF REVOCATION, THIS CONSENT WILL EXPIRE 12 MONTHS FROM THE VALID SIGNATURE. A COPY OF THIS AUTHORIZATION IS AS AUTHENTIC AS THE ORIGINAL SIGNED AUTHORIZATION OF RELEASE. AN ORIGINAL WILL BE RETAINED IN THE MEDICAL REPORT.

PATIENT SIGNATURE:____________________________________DATE: ___________

LEGAL RESPONSIBLE OTHER SIGNATURE: ____________________ DATE: __________

WITNESS: ____DATE: ___________