Counseling *Specialists*
OF CENTRAL FLORIDA

AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION

By signing this document, I authorize and permit the use and/or disclosure of my protected health information for the limited purposes and manner as described within this document. I acknowledge that I am voluntarily signing this document of my own free will or as one who has the authority to sign this document on behalf of another.

_____ _____
Client Name Date of Birth

I authorize **Counseling Specialists of Central Florida** (Counseling Specialists, Inc.), and its therapeutic or administrative staff, to: disclose to and/or obtain from:

_____ _____
Name of Entity, Facility, or Person Relationship to the Client

_____ _____
Phone Fax

The following information contained in my medical record regarding my care and treatment:

☐ Verbal Exchange of Information ☐ Written Letter or Therapeutic Summary ☐ Billing Record/Scheduling

The purpose for the release of this information at the request of the client is to coordinate:

☐ Care/Continuity of Care ☐ Legal ☐ Benefits/Payments/Scheduling

This authorization will remain in effect from the date signed until rescinded in writing by the below signed individual.

I understand that I may revoke this authorization at any time by notifying the office in writing. However, I understand that any revocation of this authorization will not affect any actions taken prior to receiving such revocation.

I understand that any information that is used or disclosed, due to this authorization, may cease to be protected by the HIPAA Privacy Rule if the recipient re-discloses the information they may obtain under this agreement.

_____ _____
Signature of Client, Parent, or Legal Guardian Date

_____ _____
Printed Name of Client, Parent, or Legal Guardian Relationship to the Client/Minor