

Your Life Family Counseling Center

7301 1st Avenue South

Saint Petersburg, Florida 33707

www.yourlifefamilycounseling.com

(727) 623-7090

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to the Counseling Center by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ authorize the Counseling Center to:

_____ release to:

_____ obtain from:

_____ exchange with:

the following information pertaining to myself:

_____ treatment summary

_____ history/intake

_____ diagnosis

_____ psychological test results

_____ psychiatric evaluation/medication history

_____ dates of treatment attendance

_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts

_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____
_____. (See back for authorization extension).

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

Signature of Client (Parental Signature if Client is a Minor) Social Security #: _____
Date

OR

Date of Birth: _____

Signature of Witness

Date

RECORD OF AUTHORIZATION EXTENSIONS

I hereby confirm that I have reviewed this consent form and agree to its extension for an additional:

Check One:

6 months OR
 other (specify) _____

Client Date Witness Date

Check One:

6 months OR
 other (specify) _____

Client Date Witness Date

Check One:

6 months OR
 other (specify) _____

Client Date Witness Date