Authorization to Release, Receive, or Exchange Information

Client Name: _____

D.O.B.: _____

Your records, which are the property of Beth Lewis, LMHC, are privileged and confidential. A general medical authorization to release or exchange psychiatric and-or psychological information is invalid according to Florida Statutes 394.459, 490.32 and Federal Regulation 42 CFR, Part 2. Your records will not be released without this waiver except under the following circumstances: In the event of a valid emergency, upon receipt of a Court Order, or upon receipt of a request which may be governed by other Florida Statutes. When exchanging information in cases where the client is involved in treatment with other agencies / professionals to assist in coordinating treatment, this authorization may include verbal as well as written communication.

I authorize ___Beth Lewis, LMHC_____to (release to) (receive from) (exchange with): circle one

_____

Name Address City/State Zip

The following information:
( ) Psychiatric / Psychological Reports ( ) History & Physical ( ) Discharge Summary
( ) Lab & X-Ray Reports ( ) HIV/AIDS Records ( ) Alcohol / Drug Abuse
( ) Treatment Planning Documentation (Individualized Treatment Plans, updates or reviews to any/all treatment plans and progress towards goals).
(x) Other (Please Specify): _progress in treatment/reports regarding underlying mental health related problems and recommended treatment

For the purpose of:
( ) Information for Physician ( ) Information for Attorney ( ) Personal Use
( ) Lab & X-Ray reports ( ) HIV/AIDS Records ( ) Alcohol / Drug Abuse
(x) Other (Please Specify): _coordination of care; ensuring effective treatment_____

I have given my consent freely, voluntarily, and without coercion. Re-disclosure of this information without further written permission is prohibited by Federal Regulations, which provide for penalties if violated.

This consent will expire upon satisfaction of the need for disclosure; at the end of treatment when exchanging information; and not to exceed 1 year after the date signed for Release of Information. I may revoke this authorization at any time providing Beth Lewis, LMHC in writing to that effect. However, such revocation will have no effect on any action previously taken.

Client Signature: _____ Date: _____

Parent / Legal
Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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