My Counseling Connections

Making Powerful Connections For Clarity, Healing and Transformation

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RELEASE OF INFORMATION

Medical Record#: ____________

I____DOB____________________SS#_____________________

Hereby give my permission to **My Counseling Connections Inc.** to release information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/AIDS and/or related conditions, and that under Florida law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my representative or otherwise provided in Florida or Federal law.

This information will be released/requested upon request to the following:

To/From: ____

Purpose of this release/request: ____

I authorize release/request of information covering treatment dates of: ______________________________________

The type of information to be disclosed/requested is as follows:

	To BE Released		To Be Requested
	Treatment Plans		Treatment Plans
	Progress Reports		Progress Reports
	Health/Medical Records		Health/Medical Records
	Education Reports		Education Reports
	Psychological/Psychiatric Evaluations		Psychological/Psychiatric Evaluations
	Social/Developmental History		Social/Developmental History
	Discharge Summaries		Discharge Summaries
	Verbal Communication		Verbal Communication
	Other: ______________________________		Other: ______________________________

_____I understand that if I revoke this authorization, I must do so in writing and present my written revocation to **My Counseling Connections Inc.**

_____I understand that I have the right withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I Release:

_____I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign , and **My Counseling Connections Inc.** will not base my treatment, or fees on whether or not I provide authorization for the requested use or disclosure. I understand that the recipient may be prohibited from disclosing substance abuse information. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).

_____I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information is no longer protected by federal confidentiality laws of **My Counseling Connections Inc.**.

_____I understand that **My Counseling Connections Inc.** will release only the minimum amount of information necessary to fulfill a request.

THIS AUTHORIZATION SHAL EXPIRE SIX MONTHS FROM THE DATE OF SIGNING AND IS SUBECT TO REVOCATION IN WRITING AT ANY TIME. EXPIRATION DATE: ______________________________

RELEASE:	REQUEST:
____	____
Signature of Client/Next of Kin/Guardian Date	Signature of Client/Next of Kin/Guardian Date
____	____
Witness: Tamar Berman, LMHC Date	Witness: Tamar Berman, LMHC Date