Emily Scott, M.S./Ed.S.

Licensed Mental Health Counselor

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION & PRIVATE HEALTH INFORMATION

PATIENT'S NAME: _____

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY #: _____-_____-_____

For the purpose of continuity of care in order to help me provide you with the best service possible, I hereby authorize Emily Scott, M.S./Ed.S., Licensed Mental Health Counselor to release:

- Verbal *and/or*
- Written information *including*:
- Psychological and Testing Reports
- Treatment Summaries/Progress Reports
- Other: _____

To: (Name) _____

(Address):_____

(Phone): _____

Further, I authorize _____ to release information to Emily Scott, Licensed Mental Health Counselor

The information to be released may include, but is not limited to: general medical, psychiatric/psychological, alcohol and drug abuse, HIV/AIDS information and/or records in accordance with Florida Statutes 394, 459, 396.112, 297.053, 90.503, 458.16, and 458.21.
I understand that this consent is revocable upon written notice to Emily Scott, LMHC except to the extent that action by Emily Scott, LMHC. has been taken in reliance on this authorization, and that this authorization shall remain in force for a one year period in order to effect the purpose for which it is given, unless resolved by patient or legal representative, as above.

Alcohol and drug use information, if present, may be disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42CFR, Part II) prohibit making any further disclosure of records without the specific written consent of the client or legal representative, or as otherwise permitted by such regulations. This information may not be used to criminally prosecute the client.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date