

AUTHORIZATION FOR RELEASE OF PSYCHOTHERAPY NOTES

HEALTH				Blvd., South, Jacksonville, FL 32216 ecords Fax: (904)733-9598
Depend On Us For Life.**	check where treated	□ SAN MARCO	1325 San Marco Blvd., Suite 500, Jacksonville, FL 32207 Attn: Medical Records Fax: (904)733-9598	
PSYCHIATRIC & PSYCHOLOGICA	L CARE	□BEACHES		rive, Bldg. B., Suite 201, Jacksonville Beach, FL 322: ecords Fax: (904)733-9598
		□ ORANGE PARK	2300 Highway 17, Suite 201, Orange Park, FL 32073 Attn: Medical Records Fax: (904) 733-9598	
Patient Name:	-			Birth Date:
Social Security No.:		Medical Record (MM	II) No.:	<u> </u>
Address:				Telephone No.:
☐ I hereby authorize Psychiatric & Psychological Care to 1	elease psychother	rapy notes concerning m	ne as indicated l	pelow to the following recipient:
Recipient:				Telephone No.:
Address:				Fax No.:
Pates of Service Needed: 1 All				ı://To://
	☐ Research ☐ Ins			
	-	Family Services (DCFS)	,	
*** If for continued care, records needed for appointment Information I do not want released under this Authoriz:		(date	e) at	(time).
mnormation 1 to not want released under this Addition	tuon.			
I understand that this Authorization will remain in effect revocation will not apply to any information already releas and that my ability to obtain treatment from Psychiatric & that I have a right to receive a copy of this Authorization. any records it releases under this Authorization. Psychiatric continuing care. I understand that State and federal law may prohibit the Reentity has no control over the Recipient and cannot, therefor & Psychological Care from any and all liability related Authorization.	ed under this Auti Psychological Car I understand that a & Psychological cipient from re-distre, guarantee that	horization. I understander will not depend in an Psychiatric & Psycholo I Care may waive such sclosing information protet the Recipient will not	d that I am und y way on whet gical Care may fee for copies ovided pursuant re-disclose sucl	der no obligation to sign this Authorization, ther I sign this Authorization. I understand charge me reasonable, cost-based fees for provided to another healthcare provider for to this Authorization, but that the releasing h information. I hereby release Psychiatric
By signing below, I authorize Psychiatric & Psychological	Care to release psy	ychotherapy notes conce	erning me as de	escribed above.
Signature of Patient		-	Date	
If (i) the patient is a minor, the patient's parent or guardian or herself, then the patient's guardian, legal representative,	should consent battorney-in-fact, s	y signing below, or (ii) surrogate or proxy should	if the patient is d consent on the	s an adult but unable to consent for himself e patient's behalf by signing below:
Signature of Representative	-	Telephone		
Name of Representative	_	Relationship to Patient		