Counseling & Development Center

AUTHORIZATION TO RELEASE RECORDS

This form when completed and signed by you, authorizes **Counseling and Development Center** to release and/or request protected information from your clinical record.

I, _____ hereby authorize the administration and clinical staff of Counseling and Development Center to release/request records, test results and/or other.

This information should only be released to / requested from: _____

_____

You have the right to revoke this authorization, in writing at any time by sending such written notification to:

Counseling and Development Center
101 East Maud St.
Tavares, FL 32778

However, your revocation will not be effective to the extent that we have taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPPA privacy Rule.

_____
PRINT NAME OF PATIENT OR LEGAL GUARDIAN

_____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE