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Authorization to Release, Receive, or Exchange Information

Your records, which are property of Jennifer Dobies, MS, MEd, Licensed Mental Health Counselor are privileged and confidential. A signed authorization to release or exchange psychiatric and/or psychological information is valid according to Florida Statutes 394.4615, 490.0147, 397.501, 90.503, 381.004, 394.459, and Federal Regulation 42 CFR, Part 2.; 45 CFR 160-164. 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, allegations of elder or child abuse, or upon receipt of a request which may be governed by other Florida Statutes, such as Worker's Compensation etc. When exchanging information in cases where the client is involved in treatment with other agencies and professionals this authorization may include verbal as well as written communication (to include clinical records). Please keep in mind that it is your responsibility to specify any information you do not want released.

CIRCLE ONE

I authorize Jennifer Dobies, MS, MEd, LMHC to: EXCHANGE WITH: RELEASE TO:

Name_____ Phone number_____
Address _____
City/State_____ Zip_____
The following information: ( )Clinical impressions and a summary of interventions
( ) Other (Please Specify): _____
For the Purpose of: ( ) Treatment Planning ( )Information for Physician ( )Information for Attorney ( )
Other (Please Specify): _____

This consent will expire upon satisfaction of the need for disclosure; and 90 days past the end of treatment when Exchanging Information; and not to exceed 1 year after the date signed for Release or Information.

I understand that I may revoke this consent in writing at any time to the extent that the therapist has not taken action in reliance on this authorization.

To the Party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of information is not sufficient for this purpose.

_____ _____
Name of Client (Print) Date

_____ _____
Client Signature Date

_____ _____
Counselor Signature/credentials Date