The Solution Counseling Center
8022 Old County Rd 54
New Port Richey FL, 34653
Phone (727) 784-8244 Fax: (800) 300-7458

## Authorization to Release/ Obtain Information

Patient Name:_______________________________________________________

SS Number:__________________ _____Date of Birth:__________________________

I Hereby give permission:

for _____________________________________(agency /individual releasing information)

Address:_______________________________________________________________

Telephone : (______)______________________Fax:______________________________

To Disclose medical, including HIV, ARC and/or AIDS Diagnosis___________(initial), psychiatric, psychological, educational, alcohol and/or drug abuse information, or any other records of sensitive nature, and may be released by copies of records, viewing of records, or verbal exchange.

This information is to be released to:__________________________________________________

For the purpose of: _______________________________________________________________

The specific information to be disclosed is:_____________________________________________

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- I understand a general medical authorization or subpoena duces tecun without specific authorization to release psychiatric/psychological information MUST have this waiver from the patient or empowered representative.
- I understand that my records have a privileged and confidential status and that I am waiving the status for the purpose contained within this authorization.
- I understand that I have the right to refuse to sign this authorization.
- I understand this authorization may be revoked at any time upon written notification, buy revocation has no effect on action already taken as a result on this authorization.
- I understand that re-disclosure of this information by the receiving agency is prohibited by law.

Signature of Patient:_______________________________________Date:________________________

Signature of Representative:__________________________________Date:_______________________

(if patient is a minor or unable to sign, legal guardianship/custody must be substantiated with legal documentation accompanying this)

Signature of Witness:________________________________________Date:______________________