Authorization for the Release of Healthcare Records

Patient Name:_____ Date of Birth:_____
(also list maiden name/other names used)

I hereby request and authorize:
JM Counseling and Jennifer Magbanua, LMFT
7651-B Ashley Park Court Suite 404
Orlando, Fl 32835

_____To Disclose information to: _____To Receive Information from:

Name:_____ Relationship to client:_____

Address:_____

Phone:_____

Information to be disclosed include copies of:
_____Entire Record
_____Other: _____
_____
_____
This authorization will be effective for one year after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

_____ Date:_____
Signature of Patient

OR

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

_____/_____ Date:_____
Signature of Legal Representative/Relationship

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.