Authorization for the Release of Healthcare Records

Patient Name:___________________________________ Date of Birth:___________

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

_______To Disclose information to: _______To Receive Information from:

Name:__________________________ Relationship to client:___________________

Email:____

Phone:____

Information to be disclosed includes copies of:

_____Entire Record
_____Entire Record except:____
_____Only the following:____

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If signing for a minor patient, I hereby state that my parental rights have not been revoked by the court of law.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