Dr. Roberta L. Marowitz, LMFT

COUNSELING & RELATIONSHIP INSTITUTE
237 Lookout Place, Maitland, FL 32751
Phone: (407) 865-3855 Fax: (321) 203-2512

Release of Information Consent

Full Client Name: _____

Client Date of Birth:_____/_____/_____ Main Phone: (_____)_____

Address: _____

City: _____ State:_____ Zip:_____

I, _____, authorize _____

To: ▢ (Send) ▢ (Receive) the following: ▢ (To) ▢ (From)

Full Name: _____

Address: _____

City: _____ State:_____ Zip:_____

Main Phone: (_____)_____ Main Fax: (_____)_____

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPPAA, IS REQUIRED FOR *PSYCHOTHERAPY NOTES.

- ▢ Academic testing results
- ▢ Behavior programs
- ▢ Progress reports
- ▢ Intelligence testing results
- ▢ Medical reports
- ▢ Personality profiles
- ▢ Psychological reports
- ▢ Psychological testing results
- ▢ Service plans
- ▢ Summary reports
- ▢ Vocational testing results
- ▢ Entire record, except progress notes
- ▢ *Psychotherapy Notes
- ▢ Other (specify) _____

The above information will be used for the following purposes:

- ▢ Planning appropriate treatment
- ▢ Continuing appropriate treatment
- ▢ Other (specify) _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice. I have been informed of what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your Relationship to the client: ▢ Self ▢ Parent/legal guardian ▢ Personal Representative
▢ Other: _____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

_____ _____/_____/_____
Signature of Client Date

_____ _____/_____/_____
Signature of Parent/guardian/personal representative (if applicable) Date