The Center for Psychological Counseling Services, Inc
5124 Hollywood Boulevard
Hollywood, Fl 33021
Tel: (954)894-1174 & Fax: (954)965-4597

Authorization for Release of Information

Date of authorization: _____
Patients Name: _____

I, _____ hereby request and authorize The Center for Psychological Counseling Services, Inc or its designees (The "Practice") to:

___ Release Records to:	___Request records from:
_____	_____
_____	_____
_____	_____
Phone: _____	Phone: _____
Facsimile: _____	Facsimile: _____

___ Check here for releasing verbal information only.
___ Check her for requesting verbal information only.

Please specify the type(s) of records to be released or being requested (indicate all that apply):

___Psychiatric ___HIV/AIDS ___Substance Abuse ___Medical/Clinical ___Other

Please specify which items are being requested
___Psychiatric Evaluation
___Psychological Evaluation/Testing
___Progress Notes
___Psychosocial History
___Consultations
___Medications
___Discharge Summary
___Treatment Plan(s)
___Other: Explain:

The purpose of this disclosure is to: _____
_____
_____

I understand that this consent is subject to revocation at any time except to the extent that action has already been taken on this authorization. This authorization shall remain in force for a reasonable time to accomplish the purpose for which it is given and will expire six (6) months from the date of consent unless a different expiration date is written here _____. (If no change from six (6) month expiration, please write NONE on the line). Read and acknowledged by:

Signature: _____ Date: _____
Or
Parent/Guardian of Minor Signature: _____ Date: _____

Rev 03/14