JENNIFER L. GLOCK, MA
Licensed Marriage & Family Therapist
Please return completed form to:
Jennifer L Glock, MA, ATTN: Medical Records 1908 River Road Jacksonville, FL 32207
or by email: glock.jennifer@gmail.com

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Jennifer L. Glock, MA, to release and/or exchange any or all information, including medical treatment, social history, psychiatric, psychological, or educational evaluation and treatment of:

______________________________ ______________ ______________
Client Name Client's Date of Birth Client's Phone Number

____
Client's Address

TO:

______________________________ ______________
Therapist/Doctor Name Therapist/Doctor's Phone #

____
Therapist/Doctor's address

This authorization shall remain in effect for a period of 1 year following the date of signing. A signed revocation may be submitted at any time, but Jennifer L. Glock, MA shall not be held liable for any information released prior to its receipt. Once the uses and disclosures have been made pursuant to this authorization, they may be subject to redisclosure by any recipient and no longer protected by federal privacy laws. I hereby release Jennifer L. Glock, MA from any liability which may arise as result of the use of the information contained in the records released.

______________________________ ______________
Signature of Client or Legal Guardian Date

____
Relationship to Patient

To receiving Agency:
PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further redisclosure is strictly prohibited unless the client provides specific written consent for the subsequent disclosure of this information.

A COPY OF THIS DOCUMENT SHALL SERVE AS AN ORIGINAL.