

Psychology Associates of Brevard

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Consent for Release of Confidential Information

I, _____, hereby grant _____ permission to

- () speak to the person/organization listed below
- () release my records to the person/organization listed below
- () release my child's records to the person/organization listed below
- () request records from the person/organization listed below
- () write a letter person/organization listed below

Person/organization authorized to release information to/from:

Name: _____ Phone: _____
Address: _____ Fax: _____

Records/information will include medical/psychological, behavioral, alcohol, and/or drug abuse information and/or school records.

Patient Name: _____
Date of Birth: _____
Soc.Sec.No.: _____

Purpose of releasing this information: _____

I understand that my records are protected under the Federal Confidentiality Regulations as well as Florida State Law. My records cannot be disclose without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time by so informing the above named parties in writing. However, such written revocation will have no effect on actions taken prior to the revocation. If I do not revoke this release, it will expire one year after I terminate with the above named party.

Signature of patient/guardian

Relationship to patient

Date

Witness

Date

Kristopher J. Olsen, Ph.D. * Robert J. Shapiro, Ph.D. * Astrid M. Sande, M.D. * Nicole Schultz, A.R.N.P.
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