Authorization to Release Information

Stephanie Roth, MA

Florida Supreme Court Certified Family Mediator | Licensed Mental Health Counselor | Collaborative Divorce Facilitator

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I, (name of client) ________________________________(hereinafter "Client") hereby authorize Stephanie Roth, LMHC, (hereinafter "Provider") to disclose collaborative divorce information and/or mental health treatment information, including, but not limited to, counselor's diagnosis of Client (if this pertains to a counseling case, not a collaborative case) to: _________________________________

I understand that I have the right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider Stephanie Roth, LMHC to be effective.

This disclosure of information and records authorized by Client is required for the following purpose:____

Provider shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form.

Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Florida law may protect such information.

This authorization shall remain valid until: _________________________________

Client's signature: _________________________________Date: ___________________