

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS

Phoenix Therapeutic Solutions, P. A.

Dr. Andrea Cuva, LMFT, MCAP

954-870-0475

3038 N. Federal Highway, Suite F-2, Fort Lauderdale, FL. 33306,

101 Plaza Real S., Suite 226, Boca Raton, FL. 33432

DOB: _____

I, _____ hereby give my permission to **Phoenix Therapeutic Solutions, P. A.**, to release or request from a third-party information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under Florida law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in Florida or federal law. This information will be released/requested upon request to the following:

To/From: _____
First and last name, phone, and address of person(s)

The type of information to be disclosed/requested is as follows:

To Be Released * from Phoenix Therapeutic Solutions, P. A.

- ___ Treatment Plans
- ___ Process Notes
- ___ Health/Medical Records (if applicable)
- ___ Letter(s) of Progress
- ___ Bio Psychosocial Evaluation/Assessment (if applicable)
- ___ Verbal Communication
- ___ Other (Specify): _____

To Be Requested * from third parties

- ___ Treatment Plans
- ___ Process Notes
- ___ Health/Medical/Academic Records
- ___ Psychological/Psychiatric Evaluations/Assessments
- ___ Court Documents
- ___ Verbal Communication
- ___ Other (Specify): _____

** In the case of notes documenting or analyzing the contents of conversation during a private counseling session ("process notes"), we reserve the right to provide a report of examination or treatment in lieu of copies of the actual records, unless requested by/for a treating psychotherapist (Florida Statute 456.057 and HIPAA Privacy Rule).*

___ (initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to **Phoenix Therapeutic Solutions, P. A.**

___ (initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and **Phoenix Therapeutic Solutions, P. A.** will not base my treatment or payment whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).

___ (initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or **Phoenix Therapeutic Solutions, P. A.** **Phoenix Therapeutic Solutions, P. A.** will not be held liable for information disclosed to another party per the client's request.

___ (initial) I understand that **Phoenix Therapeutic Solutions, P. A.** will release only the minimum amount of information necessary to fulfill a request.

This authorization shall expire when the client is discharged from the current episode of care (treatment has been completed, the client rejects/declines/drops out of treatment, is referred elsewhere, moves, or in the case of the client's death.) This agreement is subject to revocation in writing at any time.

Release:

Request:

Signature Client/Next of Kin/Guardian Date

Signature Client/Next of Kin/Guardian Date

Clinician Signature/Credentials Date

Clinician Signature/Credentials Date