www.tampabay-counseling.com
Chuck Crouse, MA, CRC, MBA, CPA
Registered Mental Health Counselor Intern
Registered Marriage & Family Therapist Intern
3825 Henderson, Blvd. Tampa, FL. 33629
813.344.1671
Suite 405
chuck@tampabay-counseling.com

AUTHORIZATION TO RELEASE INFORMATION

I, _____, (hereinafter "Patient") DOB _____

Address:_____

hereby authorize **Chuck Crouse/Tampa Bay Counseling, LLC** , (hereinafter "Provider") 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, any medical conditions including the course of medical/psychotherapy treatment of Patient, including, and not limited to, therapist's diagnosis of Patient, **to/from (include relationship if applicable)**:

TO: _____

FROM: _____

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

☐ Planning appropriate treatment ☐ Continuing appropriate treatment

☐ Other (specify) _____

Information to be disclosed/released:

☐ Treatment plans
☐ Psychotherapy notes*
☐ Entire record, except psychotherapy notes
☐ Verbal communications
☐ Court documents
☐ Assessments & tests (biopsychosocial, psychological, intelligence, academic, vocational)
☐ Health/Medical records including lab results
☐ Academic records
☐ Academic performance/discipline/plans
☐ Written communications
☐ Other _____

** 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).*

The specific limitations of the types of medical information to be discussed are as follows **(be as specific as you choose to)**:

_____

_____

Please initial page _____ _____ _____ _____ Date_____

(Continued on next page)

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AUTHORIZATION TO RELEASE INFORMATION, continued

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

Patient 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.

I understand that I have a 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 at **16120 N. Florida Ave, Tampa, FL 33549.** to be effective.

This authorization shall remain valid until: _____

Your Relationship to the client: ☐ Self ☐ Parent/legal guardian ☐ Personal Representative
☐ Other: _____

If you are the legal guardian or representative appointed by the court for the Patient, please attach a copy of this authorization to receive this protected health information.

_____
Signature of Client Date

_____
Signature of Parent/guardian Date

Other parties comprising the Patient (e.g. couple/family members)

_____
Printed Name Signature of Client Date

_____
Printed Name Signature of Client Date

_____
Printed Name Signature of Client Date