Jacksonville Center for Counseling
3560 Cardinal Point Drive, Suite # 204
Jacksonville, FL 32257

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to the Jacksonville Center for Counseling by other individuals or agencies. Such request should be referred to the original individual or agency.

I, _____, authorize the Jacksonville Center for Counseling to:

Patient Name (if different from above): _____

_____ Release to:

_____ Obtain from:

_____ Exchange with:

_____

_____

_____

The following information pertaining to myself (or my child):

_____ Treatment Summary

_____ History/Intake

_____ Diagnosis

_____ Psychological Test Results

_____ Psychiatric Evaluation/Medication History

_____ Dates of Treatment Attendance

_____ Other (Specify) _____

For the purpose, of:

_____ Evaluation/Assessment and/or coordinating treatment efforts

_____ Other (specify)_____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ Social Security #: _____

Signature of Client/Guardian Date

_____ Date of Birth: _____

Signature of Witness Date

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