REGINA BOYD, MA, LMHC
LICENSED MENTAL HEALTH COUNSELOR
165 N 4TH STREET - LAKE MARY, FLORIDA - 32746 – 321.345.9129

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I _____ authorize Regina Boyd to release/obtain information
Guardian Name
contained in my or my child(s) _____ records to/from the following
Client/Child Name & Date of Birth

individual(s) and/or organization(s) and under only the conditions below:

1. Name of person(s), organizations(s), address to whom disclosure is to be made:

Attention:_____

_____

_____

_____

Phone:_____ Fax: _____

2. Information to be disclosed:

□ Diagnosis/Assessment/Intake □ Drug/Alcohol History □ Treatment Summary
□ Attendance □ Mental Status Exam □ School Records, specify _____
□ Progress/Treatment goals □ Physical Examination □ Entire Record
□ Prognosis □ Discharge Summary □ Other _____

3. Purpose of disclosure:
□ Provision of Mental Health Services □ Collaborative Support □ Aftercare Planning
□ Continuity of Treatment □ Family Involvement □ P.O./Attorney/Judge/Court

4. Unless otherwise requested, this consent expires 30 days after discharged from treatment.

5. This consent can be revoked at any time with the written request of the parent/guardian. Any consent given will last no longer than either reasonably necessary and/or no longer than while in treatment.

I understand that this release is given to collaborate with other providers with the intent to better serve my or my family's needs. I understand that the counselor may choose not to provide the information I requested according to best clinical judgment, in order to protect my privacy, or if doing so is potentially harmful to me or my family.

_____ _____
Client (Parent/Guardian) Signature Date

_____ _____
Staff Signature Date