Megan Earles, LCSW, LLC

PHONE (941) 564-3018
FAX (941) 296-7254

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

CLIENT NAME: ___________________________________ **DATE OF BIRTH:_________________**

I hereby give my permission to **Megan Earles, LCSW, LLC**, to release/request confidential mental health, medical and/or treatment information protected by HIPPA to/from the identified person(s) named below. 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.

I authorize the release/request of information to the following person(s):

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

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

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

I authorize the type of information to be released/requested to include:

____Treatment Plans/Progress
____Process Notes
____Health/Medical Records (if applicable)
____Evaluation/Assessment/Diagnoses
____Letter(s)/Summaries of Progress
____ 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 Megan Earles, LCSW, LLC.
____(initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and Megan Earles, LCSW, LLC 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 Megan Earles, LCSW, LLC. Megan Earles, LCSW, LLC will not be held liable for information disclosed to another party per the client's 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.

_______________________________ _________________________
Signature Client Date

FOR MINORS/DEPENDENT ADULTS:

____ ______________________
Printed Name of Parent or Legal Guardian Relationship

____ ______________________
Signature of Parent or Legal Guardian Date