CHOICES COUNSELING CENTER

INFORMED CONSENT AND AUTHORIZATION FOR RELEASE OF MEDICAL, PSYCHOLOGICAL, SEROLOGICAL AND OTHER INFORMATION

I, _____ DOB:_____ SS#_____
(full name of client)

hereby authorize **CHOICES COUNSELING CENTER, Post Office Box 144, Winter Park, Florida 32790 and** _____**as my therapist(s)** to release or receive (circle one) medical, psychiatric or other pertinent serological, psychological, substance abuse including alcohol and drug information or criminal history from my medical and other records to or from (circle one): _____

_____

(name and address of agency, institution or individual to whom records are to be released or received)

I have been advised that the information to be released will be stamped "Confidential" and otherwise handled in a manner which protects my confidentiality, for the purpose of furthering my care and treatment and/or for other medical legal matters. The information to be released is for the dates commencing from: _____ to _____ _____.

I understand that re-disclosure of information obtained from other sources is prohibited, without my express written consent. I (do) (do not) [circle one] consent to re-disclosure of information obtained from other sources. I further understand that I have the privilege of revoking this written authorization at any time, provided however, I covenant and agree to submit a written notice of Revocation of Authorization to **CHOICES COUNSELING CENTER**. If I revoke this authorization then the revocation shall not become effective until received by **CHOICES COUNSELING CENTER.** I further understand that the revocation will not be effective as to information released prior to the receipt by **CHOICES** of the revocation.

I covenant and agree that this Informed Consent is made and given freely and voluntarily and I fully understand that I am waiving all my rights pursuant to Sections 90.503 and 455.667 Florida Statutes; Article I, Section 23, Florida Constitution and 42 United States Code, Section 290dd-2 and any and all other applicable state and Federal Statutes which relate in any way to the release of Psychological, Psychiatric, Medical, Serological, Substance Abuse, (alcohol or drugs) and if applicable Criminal or Juvenile Criminal History or information of any type or kind which in the opinion of **CHOICES COUNSELING CENTER,** is necessary for a full and complete evaluation of my status as a patient.

Authorization Date _____ ***Client Signature*** _____

Legal Guardian/Representative (If minor)_____ ***Date*** _____

Witness Signature/Relation to Client _____ ***Date*** _____

OFFICE USE ONLY (state specific records released) _____

_____

_____

Date of Release: ***By:*** _____

Individual or entity Medical, Psychiatric and other records released to:_____

_____

Referring Therapist:_____ Phone:_____

Client's Name:_____ SS#_____

Date of Birth:_____Sex: