PATHWAYS COUNSELING CENTER
AUTHORIZATION TO OBTAIN AND/OR RELEASE INFORMATION

Client's Printed Name:_____

Date of Birth:_____ Social Security #:_____

The above named individual, or the parent/legal guardian thereof, hereby authorizes:

Name of Therapist: _____

to obtain and/or release my records in accordance with Florida Statutes, Federal Regulations and/or HIPAA. I understand that these records have a privileged and confidential status. I am waiving that status for the purpose(s) stated herein. This authorization will remain in effect until the therapist listed above is notified in writing or 120 days after last scheduled appointment, which ever comes first.

Please ❒ Obtain the following information from: _____

Address: _____

Phone: ( ) _____ Fax: ( ) _____

Please ❒ Release the following information to: _____

Address: _____

Phone: ( ) _____ Fax: ( ) _____

Please release and/or obtain the following information (check as many as apply):

❒ Progress Notes ❒ Personal Information ❒ Treatment Plan ❒ Summary of Treatment

❒ Appointments ❒ PCP Referral ❒ Other (specify):_____

RELEASE FROM LIABILITY

I understand that these records are or may be protected by Federal Regulations and I hereby release Pathways Counseling Center, 1265 Kass Circle, Spring Hill, FL 34606 from any liability associated with the release of my information. I also understand that I may revoke this consent at any time, except where a particular action depends upon the consent remaining in effect. In any event, this consent expires automatically as noted above.

SIGNATURES

Client or Parent/Legal Guardian Signature:_____

STATE OF _____ COUNTY OF _____

Acknowledged before me this _____ day of _____, 20____ by _____

_____ who is known by me ___ OR who has produced I.D. ____.

_____
Signature of Notary

_____
Notary stamp or seal with printed name of notary