TAMPA BAY CENTER TBCforCBT COGNITIVE BEHAVIOR THERAPY

Authorization to Release, Receive, or Exchange Information

Client Name: _____ D.O.B.: _____

Your records, which are the property of TBCforCBT, are privileged and confidential. A general medical authorization to release or exchange psychiatric and-or psychological information is invalid according to Florida Statutes 394.459, 490.32 and Federal Regulation 42 CFR, Part 2. Your records will not be released without this waiver except under the following circumstances: In the event of a valid emergency, upon receipt of a Court Order, or upon receipt of a request which may be governed by other Florida Statutes. When exchanging information in cases where the client is involved in treatment with other agencies / professionals to assist in coordinating treatment, this authorization may include verbal as well as written communication.

I authorize TBCforCBT to ____ release to, ____ receive from, ____ exchange with: (choose one).

_____ _____

Name Address City/State Zip

_____ _____

Telephone Number Fax Number

The following information:

☐ Psychiatric / Psychological Reports ☐ History & Physical ☐ Discharge Summary

☐ Lab & X-Ray Repo rts ☐ HIV/AIDS Records ☐ Alcohol / Drug Abuse

X Other (Please Specify): Progress in Treatment

For the purpose of:

☐ Information for Physician ☐ Information for Attorney ☐ Personal Use

☐ Lab & X-Ray reports ☐ HIV/AIDS Records ☐ Alcohol / Drug Abuse

X Other (Please Specify): Coordination of Care

I have given my consent freely, voluntarily, and without coercion. Re-disclosure of this information without further written permission is prohibited by Federal Regulations, which provide for penalties if violated. This consent will expire upon satisfaction of the need for disclosure; at the end of treatment when exchanging information; and not to exceed 2 years after the date signed for Release of Information. I may revoke this authorization at any time by providing TBCforCBT in writing to that effect. However, such revocation will have no effect on any previous action taken.

Client Signature: _____ Date: _____

Parent / Legal Guardian Signature: _____ Date: _____

TBC Staff Signature: _____ Date: _____

TBC Staff Name Printed: _____ Date: _____

Nancy S Gordon, LCSW
President/Founder

PO Box 14 Brandon, Fl. 33509
219 Cook St. Brandon, FL 33511
mailto:admin@tbcforcbt.com
www.tbcforcbt.com

Office: (813) 480-8482
Fax: (813) 651-4402