FLORIDA ART THERAPY SERVICES, LLC
AUTHORIZATION TO RELEASE OR REQUEST INFORMATION

CLIENT NAME:_____ DOB:_____
Authorization for (Initial appropriate)_____ Request Information _____ Release of Information

I hereby authorize Florida Art Therapy Services, LLC to disclose mentla health treatment information and records obtained in the course of psychotherapy treatment of client, including, but not limited to the psychotherapist's diagnosis. This information may be released to/ requested of the following:
FACILITY NAME:_____
FAX:_____
ADDRESS:_____
I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless *Provider* has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at 5272 Summerlin Commons Way #602 Fort Myers, FL 33907 to be effective.

This disclosure of information and records authorized by client is requested for the following purposes:
_____ Gathering/Sharing Medical History _____ Coordination of Care
Other:_____

The specific uses and limitations of the types of medical information to be discussed are as follows (be as specific as you chose to): _____
_____

Such disclose shall be limited to the following types of information: _____Diagnosis
Psychological/Psychiatric Assessments _____ Progress Notes_____ Entire Clinical Record_____

Psychotherapist shall not condition treatment upon client signing this authorization and client has the right to refuse to sign this form. Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA privacy rule.

This authorization shall remain valid until (specify date, but may not be greater than 1 year from today)
_____

Client Signature:_____ Date:_____
Parent/Guardian Signature (if applicable):_____ Date:_____

_____ Date:_____
Reina Lombardi, MA, ATR-BC, ATCS, LMHC #MH12643
Licensed Mental Health Counselor

Last Updated 03/02/2018