Weston PsychCare, P.A.
2625 Executive Park Drive
Suite 3
Weston, Florida 33331
954-385-4696

AUTHORIZATION TO OBTAIN AND RELEASE PRIVATE HEALTH INFORMATION

PATIENT NAME: ____

ADDRESS: ____

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I hereby authorize and request ________________________ to obtain and release any and all confidential professional information including personal, psychological, psychometric, medical records and opinions, and educational information resulting from y contacts with him/her and to:

NAME OF PERSON AND AGENCY: _____________________________________

ADDRESS: ____
____

PHONE: ____

I understand that I may revoke this consent, in writing, at any time by informing any of the above noted individuals.

I hereby release the above parties from any and all liability arising therefrom. This consent, unless revoked in writing, is in effect for one year from the date of signature.

Kindly accept a photocopy or PDF of this authorization as if it were an original executed authorization. Your cooperation is respectfully requested.

SIGNATURE: ____________________________ DATE: ________________

PARENT/GUARDIAN______________________ DATE: ________________

WITNESS: _______________________________ DATE: ________________