Weston PsychCare
12401 Orange Drive Davie, Suite 224, FL 33330
954-385-4696

AUTHORIZATION TO OBTAIN AND/OR RELEASE PRIVATE HEALTHCARE INFORMATION

Patient Name: _____

Patient Address: _____

_____

I hereby authorize and request (Therapist Name)_____ to

_____obtain

_____release

any and all confidential professional information including personal, psychological, psychometric, clinical records and opinions, and educational information resulting from my contacts with him/her from and to:

Name or Person: _____

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. Kindly accept a photocopy or computer generated copy or fax as if it were an originally executed authorization.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____