



MindWorks Psychological Services
 7450 Dr. Phillips Blvd. Suite 312, Orlando, FL 32819
 310 S. Dillard Street Suite 160 Winter Garden, FL 34787
 Phone 407.415.1450 Fax 321.234.5587
<http://www.MindWorksPsych.com>

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS

MindWorks Psychological Services

CLIENT NAME: _____

I have the authority to consent for this minor child and give my permission to **MindWorks Psychological Services**, to release or request from a third party information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under Florida law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in Florida or federal law.

This information will be released/requested upon request to the following:

To/From: _____

First and last name, phone, and address of person(s)

The type of information to be disclosed/requested is as follows:

To Be Released * from MindWorks Psychological Services **To Be Requested** * from third parties

- | | |
|---|--|
| <input type="checkbox"/> Treatment Plans | <input type="checkbox"/> Treatment Plans |
| <input type="checkbox"/> Process Notes | <input type="checkbox"/> Process Notes |
| <input type="checkbox"/> Health/Medical Records (if applicable) | <input type="checkbox"/> Health/Medical/Academic Records |
| <input type="checkbox"/> Letter(s) of Progress | <input type="checkbox"/> Psychological/Psychiatric Evaluations/Assessments |
| <input type="checkbox"/> Bio Psychosocial Evaluation/Assessment (if applicable) | <input type="checkbox"/> Court Documents |
| <input type="checkbox"/> Verbal Communication | <input type="checkbox"/> Verbal Communication |
| <input type="checkbox"/> Other (Specify): _____ | <input type="checkbox"/> Other (Specify): _____ |

** In the case of notes documenting or analyzing the contents of conversation during a private counseling session ("process notes"), we reserve the right to provide a report of examination or treatment in lieu of copies of the actual records, unless requested by/for a treating psychotherapist (Florida Statute 456.057 and HIPAA Privacy Rule).*

____(initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to **MindWorks Psychological Services**.

____(initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and **MindWorks Psychological Services** will not base my treatment or payment whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).

____(initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or **MindWorks Psychological Services** will not be held liable for information disclosed to another party per the client's request.

____(initial) I understand that **MindWorks Psychological Services** will release only the minimum amount of information necessary to fulfill a request.

This authorization shall expire when the client is discharged from the current episode of care (treatment has been completed, the client rejects/declines/drops out of treatment, is referred elsewhere, moves, or in the case of the client's death.) This agreement is subject to revocation in writing at any time.

_____ Signature Client/Next of Kin/Guardian	_____ Date	_____ Clinician Name/Credentials	_____ Date
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