Lori B. Bohnert, MS, LMHC
2973 West SR 434
Suite 400
Longwood, Florida 32779
407-449-0751 (phone)

AUTHORIZATION
TO RELEASE AND OBTAIN CONFIDENTIAL INFORMATION

This form when completed and signed by you, authorizes us to release and/or obtain protected information from your clinical record with the person you designate.

Client's name _____ D.O.B _____
I have been informed that under Florida law, communications between a client and his or her psychiatrist, psychologist or therapist are privileged and may not be disclosed by the clinician unless the client consents. I have also been informed that client records may not be disclosed to third parties except with the client's consent or through legal process.

I hereby authorize Lori B. Bohnert, MS, LMHC to release and/or obtain information of a psychological, psychiatric, medical, alcohol- or drug-related nature to and/or from:

Name (practitioner, agency, facility, or individual) _____

Address of same _____

City, State, zip _____

Phone number _____ fax _____

I am requesting my clinician to release or obtain this information for the following reasons ("at the request of the individual" is all that is required, if you are our client and you do not desire to state a specific purpose):

_____

This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure):

_____

This authorization is fully understood by me and is made voluntarily. I understand that I may revoke this consent at any time, that such revocation must be in writing, and that it will be effective except to the extent that action based on this consent has already been taken, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my clinician generally may not condition psychological or counseling services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of my information, and no longer protected by the HIPAA Privacy Rule.

Signed _____ Date _____

_____ (initials) I acknowledge that I have received a copy of this authorization.