John Cutrone, LMHC, LLC
6810 Lyons Technology Circle, Suite 125, Coconut Creek, FL 33073
Phone: (561) 289-9722 Fax: (561) 544-7149 Website: www.CutroneLMHC.com

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION (When Client is 17 and Under)

I, _____, DOB:_____ SS#_____
Guardian of Client's Name (PLEASE PRINT)

hereby give my permission to John Cutrone, LMHC, LLC, or to the entity listed below to release information contained in my minor child (Client),_____'s, medical record. I understand that the medical record may contain information concerning his or her psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency (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:_____
Name and Address of Person(s), Agencies, Organization to which information is to be released/requested from.

Purpose of this release/request:_____

I authorize release/request of information covering treatment dates of:_____

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

TO BE RELEASED

_____ Treatment Plans
_____ Progress Reports
_____ Health/Medical Records
_____ Education Reports
_____ Discharge Summaries
_____ Psychological/Psychiatric Evaluations
_____ Social/Developmental History
_____ Verbal Communication
_____ OTHER:_____

TO BE REQUESTED

_____ Treatment Plans
_____ Progress Reports
_____ Health/Medical Records
_____ Education Reports
_____ Discharge Summaries
_____ Psychological/Psychiatric Evaluations
_____ Social/Developmental History
_____ Verbal Communication
_____ OTHER:_____

_____ (Initial) I agree to allow authorized personnel, from John Cutrone, LMHC, LLC, to receive a copy of my medical record.

_____ (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 John Cutrone, LMHC, LLC.

_____ (Initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and John Cutrone, LMHC, LLC will not base my treatment, payment, or eligibility for benefits on whether or not I provide authorization for the requested use or disclosure. I understand that the recipient may be prohibited from disclosing substance abuse information. 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 John Cutrone, LMHC, LLC.

_____ (Initial) I understand that John Cutrone, LMHC, LLC, will release only the minimum amount of information necessary to fulfill a request.

This authorization shall expire on the expiration date below, not to exceed twelve months from the date of signing, and is subject to revocation in writing at any time.

Expiration date:_____

Release:

_____
Guardian Signature **Date**

_____
Witness **Date**

Request:

_____
Guardian Signature **Date**

_____
Witness **Date**