17862 Hunting Bow Circle Lutz, Fl. 33556
www.SolutionsFamilyTherapy.com
(727) 612-4077

Authorization for Release

I authorize Solutions Family Therapy to disclose my health information to the persons listed below. This includes any records, reports, test results, opinions, assessments and any other information relating to medical, emotional, educational, or psychological conditions.

I can revoke this agreement at any time by sending a written notice to the Solutions Family Therapy office where I am receiving services.

I understand that information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by Solutions Family Therapy confidentiality rules.

I waive any right of privacy that I may have in connection with the disclosures hereby authorized.

This authorization is valid until three months after my file is closed at Solutions Family Therapy.

Insurance Company: ____ Client's Initial: _______

Name: ____ Client's Initial: _______

Name: ____ Client's Initial: _______

Name: ____ Client's Initial: _______

Name: ____ Client's Initial: _______

Client's Signature: ____ Date: ______________

Client's Signature: ____ Date: ______________

Witness: ____ Date: ______________