RELEASE OF CONFIDENTIAL INFORMATION

5/06

I ____

Name Address

authorize Lisa A. Smith ,2180 N. Park Ave., Winter Park, Fl. 32789, 407-629-6448 to disclose

to ____

Name/Agency Address

information about ________________________, birth date________________ for the following purpose:

☐ further treatment ☐ treatment planning & managed care/insurance benefits.

These records concern the time between ___________________and________________.

I understand that my records are protected under Federal (42CFR Part 2) and/or State Confidentiality Regulations. This authorization may be withdrawn at any time in writing except to the extent that the program or person which is to make this disclosure has acted in reliance on it. Upon revocation of authorization, further release of information shall cease immediately. File copy is considered equivalent to the original. This release of information expires in 6 months. I hereby release Lisa Smith from any and all liability arising there from. I have read and received a copy of this release. I consent of my own free will.

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Signature Print Date