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Authorization to Release or Disclose Confidential Information

1. I, _____, the undersigned, hereby authorize and request that Patrick B. McGinnis, PhD, LMHC, (and/or the person/agency in #2 below) release, exchange, and/or obtain the following confidential information and/or records:

(√ Check all that apply or specify after Other)

___ My status as a client

___ Treatment Plans

___ Psychosocial history,
assessment and
recommendations

___ Psychological/psychiatric evaluations

___ Copy of File

___ Pertinent progress notes

___ Other testing results

___ Other _____

2. This information is to be released to, released by, or freely obtained from:

I understand that my records may be protected, in full or in part, under the Federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 43 CFR, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that this consent is valid for one year or until _____. I understand that I may revoke this consent at any time, either verbally or in writing, except to the extent that the disclosure has already been acted upon. I agree that a faxed copy of this release form is as valid as the original.

Signature & Date

Witness Signature & Date

Print Witness Name and Contact Number