KATZ COUNSELING
& EDUCATIONAL PSYCHOLOGY, INC.

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Fort Myers, FL 33907
Tel: 239-247-1756 **Fax:** 239-690-2438 (fax)
www.katzpsychology.com

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name: _____ Date of Birth: _____

I, _____
(Print Client, Parent, Guardian, or Legal Representative's Name)

hereby authorize and request that Katz Counseling and Educational Psychology disclose and/or obtain from:

Name:_____
(Insert name of person or organization that you are authorizing to release/receive information)

Phone:_____ Fax:_____

The following information: (***Please mark which information to share below***)
_____Relevant mental health, medical, educational, family history, or legal information
_____Billing & Scheduling Information

List any information that you do **not** wish to disclose_____

This information will be used to facilitate treatment and/or evaluation of myself or my child.

This authorization shall remain in effect until (***check one***):

____ Treatment/assessment has been completed.
____ Date: _____
____ Event: _____
(fill in an event that relates to the individual or the purpose of the use or disclosure)

I understand that I may revoke this authorization, in writing, at any time by sending such written notification. I also understand that information used or disclosed pursuant to this authorization may be subject to be disclosure by the recipient and is no longer protected by HIPAA Privacy Rules. I further understand that information received from third parties may be protected information and unable to be disclosed by this office upon receipt.

_____ _____
Signature of Client, Parent, Guardian, or Legal Representative Date

_____
Printed name of Client, Parent, Guardian, or Legal Representative