Lifestyle Center for Counseling & Nutrition
Treatment Policies and Procedures

2380 Third Street South-Suite 2, Jacksonville Beach, FL 32250
Phone (904) 614-5521 Fax (904) 328-2083
mitzygator@yahoo.com

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, born on ___/___/_____, hereby authorize the release of information which may be acquired by Lifestyle Center for Counseling & Nutrition in a professional capacity to the following individual, agency insurance companies on my behalf:

_____

Located at _____
(address, city, state, zip)

Phone: _____

I, _____, hereby authorize _____(staff name)

my therapist/dietician (circle one), to disclose/obtain the following information from clinical records:

___ Entire record
___ Summary of treatment
___ History & Background
___ Complete treatment record
___ Educational record
___ Other: _____

___ Diagnosis and dates of treatment
___ Psychological Evaluation
___ HIV status, if relevant
___ Substance abuse history
___ Legal information

about me/my child _____

for the following purpose _____

I agree that a photocopy of this release form is acceptable, and I understand that I have the right to receive a copy of the authorization form upon my request. I may revoke the consent to release information at any time. I also understand that any release of information which has been made before any revocation and which is based upon this authorization, shall not constitute a breach of my right of confidentiality.

_____ _____
Signature of client/guardian Printed Name

_____ _____
Authorization Date Witness

Relationship to Client: ___ Self ___Guardian ___ Parent of minor ___ Person legally authorized on client's behalf