Veronica Lichtenstein LMHC

LET'S TALK ABOUT IT

Authorization to Release Information

Name of Client _____ Date of Birth _____

I authorize Veronica Lichtenstein, LMHC (hereinafter "Provider") to disclose/obtain mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to therapist's diagnosis, of the client listed above to:

Name of Individual or Organization _____ Phone _____

Address _____ Fax _____

City _____ State _____ Zip _____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider to be effective. I understand that this authorization will automatically expire after 1 year.

Provider shall not condition treatment upon my signing this authorization and I have the right to refuse to sign this form. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Florida law may protect such information.

Signature _____ Date _____

Your relationship to the client: ☐ Self ☐ Other*

If other, please provide your legal name and relation to the client:

_____

*If you are not the client, you may be asked to provide documentation on your authority to act on behalf of this individual.

Revised 12/27/22