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AUTHORIZATION TO USE/ DISCLOSE AND REQUEST MY HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I. My Authorization

I authorize **Daniel S. Marr, Psy.D., P.A.** to use/ disclose and to request my mental health information:

You may use or disclose the following health information (check all that apply):

☐ All my health information
☐ My health information related to the following treatment or condition: _____
☐ My health information for the dates: _____
☐ Other: _____

Information released from clinician may include review of and/ or copies from the patient's medical record. I understand the information to be released may include information regarding drug abuse, alcohol abuse, psychological or psychiatric impairments, or physical conditions including HIV/ AIDS information.

You may disclose/ request this information to/ from:

Name (or title) of Person/ Organization: _____

Address: _____ City_____ State _____ Zip _____

Phone: _____ Fax: _____

Reason(s) for this authorization (check all that apply):

☐ At my request
☐ Other (specify) _____
☐ Check here only when authorization is for marketing purposes
☐ Check here only when person/ organization will get something of value for providing health information for marketing purposes

This authorization ends: ☐ on (date) _____
☐ when the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (i.e., treatment). However, I do have to sign an authorization:

- To take part in a research study
- To receive health care when the purpose is to create health information for a third party

I may revoke this authorization in writing. If I choose to revoke this authorization, it will not affect any actions taken by the person/ organization releasing my information based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

I certify that this authorization is made voluntarily. I understand that the information to be released is protected under State and Federal laws and cannot be re-disclosed without my further written consent unless otherwise provided for by State and Federal laws.

_____ _____
Signature of Patient or legally authorized individual Date

_____ _____
Printed Name if signed on behalf of patient Relationship (parent, legal guardian, etc.)

The enclosed medical/psychiatric/psychological information is released in accordance with Florida statutes 90.24, 490.32 and/or 90.503, 458.16, and 394.459(9) and by Federal law (42CFR Part 2). Federal and State regulations prohibit any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. If you have received this information in error, destroy immediately and call us to inform us of the error. Thank-you.