Village Counseling Center

HELP AND HOPE FOR CHILDREN AND FAMILIES

COMPREHENSIVE AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

Client Name: _____ **Date of Birth:** _____

Social Security #: _____ **County of Residence:** _____

This authorizes the Village Counseling Center, Staff and Independent Practitioners to release and/or receive general medical, psychiatric/psychological, assessment and/or school information from my client records in accordance with Florida Statues and Federal Administrative Rules and Regulations. The Village Counseling Center, Staff and Independent Practitioners are all released from any legal liability that may arise from the release/receipt of the information requested.

Agencies and parties to and from authorization pertain: ***(Please mark all boxes that apply)***

- ☐ Department of Children and Families (DCF)
- ☐ Department of Juvenile Justice (DJJ)
- ☐ Guardian ad Litem Program (GAL)
- ☐ Meridian Behavioral Healthcare, Inc.
- ☐ Partnership for Strong Families (PSF)
- ☐ Public Defender's Office
- ☐ Office of the State Attorney
- ☐ Alachua County School Board/Program
- ☐ Mental Health Provider/s: _____
- ☐ Extended Family Member/s: _____
- ☐ Foster Parent/s: _____
- ☐ Non-Relative Placement: _____
- ☐ Medical Provider/s: _____
- ☐ School/s: (Include county) _____
- ☐ OTHER/S: (Please list) _____

Information to be released is as follows: ***(Please mark all that apply)***

- ☐ History, Physical, Lab Work
- ☐ Legal/Court Records
- ☐ Psychiatric/Psychological Reports
- ☐ Educations and School Records
- ☐ Social History
- ☐ Treatment and/or Substance Abuse Records

This authorization will be valid for 365 days from the date specified below or until the client identified above is discharged from treatment, whichever is latest. I understand that I have the right to terminate this authorization at any time by sending a written statement indicating such to the Village Counseling Center, except to the extent that action has already been taken in accordance with the above authorization. This authorization will be valid for all methods of communication (e.g., phone, fax, email, , video, etc.). **Prohibition on re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by law. Any further release or re-disclosure is strictly prohibited.**

Client or Parent/Legal Guardian Signature	Printed Name	Date
Witness Signature	Witness Printed Name	Date