AUTHORIZATION FOR OBTAINING OR RELEASING CONFIDENTIAL INFORMATION

I, ________________________________ Address ____

Authorize: Nicolle Arbelaez Lopez, Psy.D., CEDS
1640 Town Center Circle, Suite 204
Weston, Florida, 33326
Phone: (954) 804-5144 Fax (954) 302-9145

To Obtain:

( ) Treatment Summary
( ) Psychological Evaluation/Testing
( ) Psychiatric Evaluation
( ) Treatment Plan and/or Progress
( ) HIV and/or Drug/Alcohol Abuse/Addiction
( ) Information re: Emergency Treatment and AMA
( ) Other: ___________________________________
( ) Discharge Summary
( ) Medical History
( ) Consultation

From the following:

Name: ____

Address: ____

____

Phone: ____

To Release:

( ) Psychological Evaluation
( ) Treatment Plan and/or Progress
( ) HIV and/or Drug/Alcohol Abuse/Addiction
( ) Information re: Emergency Treatment and AMA
( ) Other: ________________________________
( ) Psychological Testing
( ) Consultation

To the Following:

Name: ____

Address: ____

____

Phone: ____

I understand that my records are confidential and will not be disclosed without my written consent unless under legal compulsion. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance therein. Further, this release will remain in force throughout treatment.

Date: _____________ Signature of Client: ____

Signature of Parent/Guardian: ____

Witness: ____

I hereby revoke my consent:

Date: _____________ Signature of Client: ____

Signature of Parent/Guardian: ____

Witness: ____