Karen Berner Arcuri, LMHC
Cypress Creek Therapy & Relationship Center

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AUTHORIZATION TO EXCHANGE INFORMATION
VERBAL ■ WRITTEN ■ ELECTRONICAALY

CLIENT NAME:_____ DOB_____

This will authorize Karen Berner Arcuri, LMHC to exchange general medical psychological/psychiatric, or alcohol & drug abuse information regarding the above named client, either in writing, verbal or electronically in accordance with applicable Florida Statutes, Code of Federal Regulations, Health Insurance Portability and Accountability Act of 1996 with:

Name;_____ Relationship:_____

Agency: - _____

Address:_____

City, State, Zip_____Phone #_____

Fax #_____Cell Phone #_____

INFORMATION TO BE EXCHANGED INCLUDES:

☐Psychosocial History ☐Psychiatric Evaluation Medication/History ☐Substance Abuse History and Treatment

☐Treatment/Counseling History (# of sessions, frequency of sessions, level of care, additional recommendations)

☐School Attendance & School Performance

☐Client compliance with recommended treatment ☐Discharge Summary and Recommendation

☐Other_____

This information is needed to ensure continuity of care for the above named client.

I understand this authorization is to exchange information with the party listed above.

I understand that all information is held strictly confidential.

I understand that this authorization to release information is valid until revoked in writing or no longer than 90 days post discharge.

This information is prohibited by law from further disclosure or re-disclosure without my written consent.

_____ _____

Client Signature Date

_____ _____

Parent (Guardian) Signature - if applicable Date

_____ _____

Povider/Witness Signature Date