BlueSky Children and Family Therapy, LLC
Nancy Miller, LMHC

Licensed Mental Health Counselor

125 N.Blecher Road Clearwater, Fl 33765

AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

CLIENT NAME		DATE OF BIRTH	

___ I am the individual named above
___ A legal guardian/personal representative because the client is a minor, incapacitated or deceased

I give permission for **BlueSky Children and Family Therapy LLC, Nancy Miller LMHC** to:
___Release information to:
___Obtain information from:

NAME OF PERSON / ORGANIZATION		PHONE NUMBER	

The specific information to be disclosed is:

___Psychiatric Evaluation	___Assessment (Counseling or Targeted Case Management)	Communication: Specify by circling Phone Email Written
___Medication Record	___Treatment Plan / Service Plan	___Other (Specify):
___History and Physical Exam	___Treatment Summary	
___Educational Information	___Discharge Summary	
___Psychological Testing	___Substance Abuse Treatment	

FOR THE PURPOSE OF: ___Coordination of Care ___Other (specify):

I hereby authorize the disclosure of protected health information about the individual named above. I understand that my records have a privileged and confidential status. I am waiving that status for the purpose contained in this authorization.

- I understand that I do not need to sign this form in order to obtain enrollment, eligibility, treatment or payment for services.
- I understand that I have the right to refuse to sign this authorization and do not have to agree to authorize any use or disclosure.
- I understand that I can revoke this authorization at any time upon written notification to the provider named above. I further understand that revocation will not apply to information that has already been used or disclosed.
- I understand that I am authorizing the release of information from records whose confidentiality and privileged status is protected by Federal Regulations and Florida Statutes. However, the recipient of this information may not have to abide by the same federal and state privacy laws.
- I understand that I have a right to receive a copy of this authorization once I have signed it or may ask for a copy at any time by contacting the provider named above.

This authorization is valid for: ___a single disclosure, OR ___up to ninety (90) days, OR ___ continuing disclosure for up to one year from the date of my signature as it appears below

Signature of Client (If minor, Parent and/or Legal Guardian/Authorized Representative must also sign) Date

Signature of Parent / Legal Guardian / Authorized Representative (circle all that apply) Date

Signature of Parent / Legal Guardian / Authorized Representative (circle all that apply) Date