Comprehensive Authorization to Release/Receive Information

Client Name ____ DOB ______________

This authorizes Oaks Family Counseling 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. Oaks Family Counseling is 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)
- ☐ Guardian ad Litem Program (GAL)
- ☐ Meridian Behavioral Healthcare, Inc.
- ☐ Alachua County School Board
- ☐ Office of the State Attorney
- ☐ UF Health/Shands Providers
- ☐ Mental Health Providers: ____
- ☐ Medical Providers: ____
- ☐ Schools: ____ County __________________
- ☐ Extended Family Members: ____
- ☐ Non-Relative Placement: ____
- ☐ Foster Parents: ____
- ☐ Others (Please list): ____

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

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

This authorization will be valid for one (1) year 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 Oaks Family Counseling, 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 (phone, fax, mail, email).

Signature of Client or Parent/Guardian ___________________________________ Date __________

Witness Signature _______________________ Name ______________________Date __________