ORLANDO PSYCHOLOGY ASSOCIATES
1630 HILLCREST ST. ORLANDO, FL. 32803
PH: (407) 447-5437 FAX: (407) 447-4543

Authorization for Release of Confidential Information

I, _____, authorize _____ (provider name) to release and/or obtain information including that of a psychological, psychiatric, medical, alcohol or drug related nature, on the following person(s):

Patient: _____

Address: _____

City/St/Zip: _____

DOB: _____ SSN: _____

This information is to be Released To/ Obtained From:

Name: _____

(Attention): _____

Address: _____

City/St/Zip: _____ Phone: _____
(Address Must Be Provided in Order to Expedite Release)
Fax: _____

For the purpose of and type of information shall include: _____

_____ _____
Patient/Guardian Date Relationship to Patient

_____
Doctor's Authorization Date

I recognize that the information disclosed may contain information that is privileged and protected by law. I specifically consent to the disclosure of such information and acknowledge that I have the right to not authorize the disclosure of this information. I understand that I have the right to revoke this release at any time.This release will expire two years from the date signed.