TAMPA COUNSELING AND WELLNESS

Consent to Obtain or Release Information

Client Name: _____ DOB: _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____-_____

This form authorizes me to release and obtain information about your clinical record to another person or organization.

[x] I authorize Dr. Carlos Garcia to release information from my clinical record, including history, treatment plans, progress notes, testing and discharge information.

[x] I authorize Dr. Carlos Garcia to obtain information from my clinical record, including history, treatment plans, progress notes, testing and discharge information.

[x] This request specifically includes Mental Health and/or Psychiatric Records.

The purpose of releasing/obtaining this information is:

[x] Treatment coordination ☐

Other:_____

This information may only be released to or obtained from:

Name of Individual/Organization: **Dewayne Kimble/KMD89 VA Claims Consulting**

Address of Individual/Organization: **235 Apollo Beach Blvd. Box166**

Apollo Beach, FL 33572

Phone: **(855) 765-3137** Fax: **(813) 672-9223**

This consent will remain in place [x]r: ☐ One year ☐ Other period: _____

I understand that:

I can revoke this consent at any time by sending written notice of my request to revoke consent to my therapist. The revocation will not apply to records or information already released. I am under no obligation to sign this release and refusal to do so will not affect my ability to obtain treatment from my therapist. Although Florida law prohibits re-release of this information by the recipient, my therapist cannot guarantee that the recipient will not re- disclose the information. By Florida law, if records regarding family or couple therapy are requested, all parties must provide written consent.

My therapist will provide the information in a timely manner. It may take time from the receipt of this signed authorization for materials to be retrieved, duplicated or summarized for release. Accepted requests will be completed within 30 days. There may be a charge for copying and handling this request. Applicable fees per state law will apply. By signing this authorization, I agree to pay those fees.

Signature of Client or legal representative: _____

Printed Name of Client or legal representative: _____

Date: _____