Riverside Counseling Center • Ft. Myers, Florida

Client Authorization for Release/Request of Information And Waiver of Privilege of Confidentiality

Client Name: _____

Authorization for (check as approriate): ☐ Request for Information ☐ Release of Information

I authorize Riverside Counseling Center a ministry of Riverside Church to request/release information relating to, and records of the client named above. This release is pursuant to Federal Regulations (Title 42, US Code, sections 290dd-3 and 290ee-3 and CFR Part 2) and Florida Statutues (FS 90.503, 90.5035, chapters 381, 382, 383, 384, 390, 391, 392, 393, 394, 395, 396, 397, 415, 445, 490, 491).

If this authorization covers information pertaining to a minor child, the undersigned represents that he/she is the legal guardian and primary custodian of the minor, with full authority to execute this authorization and release.

I understand that this release not only covers the provision and receipt of all records maintained by Riverside Counseling Center, but also authorizes any member of the staff, employee of, or entity contracting with Riverside Counseling Center to discuss the case, treatment, and records with the persons authorized to receive information either in private conversations, depositions, or court testimony.

I have read and fully understand the terms of this release and waiver.

Information covered by this authorization may be released to and/or requested from the following:

Facility/Person _____
Address _____
The information and records are for the purpose of _____
Information to be released includes (check one):

- ☐ All information including medical, psychiatric, psychological, HIV/Aids, alcohol/drugs or other substances
- ☐ Specific information/reports, such as _____

Facility/Person _____
Address _____
The information and records are for the purpose of _____
Information to be released includes (check one):

- ☐ All information including medical, psychiatric, psychological, HIV/Aids, alcohol/drugs or other substances
- ☐ Specific information/reports, such as _____

I understand that I may revoke this authorization (except to the extent that action has already been taken) by written notification to Riverside Counseling Center. If I do not revoke this authorization, it automatically expires as follows: Please initial one choice: ☐ Six months after counseling completion ☐ On ___/___/___

Signature _____ Date _____

Witness Signature _____ Date _____