fischer.cbt
Udo Fischer, PhD, LMHC, Dipl. Psych.
801 Laurel Oak Dr., Suite #714
Naples, FL 34108
239 595-0558

AUTHORIZATION TO RELEASE OR REQUEST INFORMATION AND WAIVER OF PRIVILEGE OR CONFIDENTIALITY

(1)_____ (2)_____
NAME DATE OF BIRTH

This will authorize Udo Fischer, PhD, LMHC, Dipl. Psych. to:
(3)Release information to _____(please initial) / Request information from _____(please Initial)

(4) Name of Individual/Agency:_____
Address (City, State, Zip):_____
Phone Number:_____

(5) INFORMATION TO BE RELEASE or OBTAINED. (Please initial each item to be released or obtained)
_____Treatment/Discharge Summary _____Verbal Exchange of Information
_____Psychiatric/Psychological/Clinical Assessment _____Other_____
_____Alcohol and Drug or other Substances _____I also authorize the faxing of the initialed items

(6) Specific purpose for disclosure of record:_____
This release is pursuant to Federal Regulations (title 42, US Code, sections 290ee-3 and CFR Part 2) and Florida Statutes (FS 90,503,90.5035, chapters 381,382,383,384,390,391,392,393,394,395,397,416,445,490,491) and (45 CFR 160-164).

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 to release or request information. If guardian is unable to sign and a personal representative is signing on behalf of guardian's proof of representative's authority must be attached to this authorization. I understand that fischer.cbt cannot refuse services if I refuse to sign this consent to release or request information. I understand that this release not only covers the provision and receipt of all records maintained by fischer.cbt, but also authorizes member of the staff, employee of, or entity contracting with fischer.cbt to discuss the case, treatment and records with the persons authorized to receive information either in private conversations, depositions, or court testimony.

This information is disclosed to recipient from records that are confidential and protected by Florida Law (394.459, 397.053, 381.609), 455 and 90.) I understand that my records are protected under the federal regulations governing confidentiality (42 CFR Part 2), (45CFR 160-164) and cannot be disclosed by provider without my written consent unless otherwise provided for in the regulations. I understand that my information is subject to redisclosure by the recipient and is no longer protected by the Privacy rules.

I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.
I may revoke my authorization by notifying in writing to fischer.cbt.

I have read and fully understand the terms of this release and waiver. (7)_____(please initial)

(8)_____
Client Signature Date

(9)_____
Signature of Parent/Guardian Date

(10)_____
Witness/Staff Signature Date