Elisa A.M. Horton, LMFT, LMHC, NCC, Inc. DBA **Better Together Counseling** - Fl License Numbers MT 2182, MH 8749

Authorization for Release/Exchange of Information

I, Client name (person whose records are being requested):_____ DOB: _____

hereby request and authorize:

_____

(Name of person(s) or agency you'd like Better Together Counseling/Elisa Horton, LMFT, LMHC, NCC, Inc. to interact with – e.g. name of your doctor)

_____

Street number, street address, city, state, & zip code (e.g. the above doctor's address)

(_____) _____ (_____) _____

(Area code) Phone number (Area code) Fax number

to ❍ release or ❍ exchange medical, education, mental health, or other pertinent information from my record with Better Together Counseling/Elisa Horton, LMFT, LMHC, NCC, Inc. at 901 SW Martin Downs Blvd, Ste. 317, Palm City, Fl 34990 Phone: (772) 781-1818; Fax (772) 781-8388 for the purpose of best practices and/or continuity of care of: _____ _____ (the client who's record this authorization pertains to).

The specific information to be disclosed is:

- ☐ Psychiatric treatment, evaluation(s) and record(s)
- ☐ Psychological testing and evaluations
- ☐ Inpatient or Outpatient Treatment Records
- ☐ Mental health/Counseling records/information
- ☐ Substance use treatment records (initial _____)
- ☐ Medical information (include HIV/AIDS – initial _____)
- ☐ Verbal/written communication about checked items
- ☐ Other: _____

I understand this authorization is voluntary and will automatically be revoked upon termination of treatment with Better Together Counseling. I understand that I have the right to refuse to sign this authorization without penalty. I further understand that I have the privilege of revoking authorization at any time, provided that I provide written notice. However, this revocation will not effect information released prior to the written revocation. This release shall be in compliance with federal regulations (42 CFR, part 2, Section 33 of Public Law 910616 as amended by Public Law 93-282) and will comply with all applicable state and local laws, rules, and regulations.

_____	_____	_____	_____
Signature of Client	Date	Signature of Parent/Legal Guardian	Date

Pursuant to Florida Statue § 491.0147(2) – The above client is part of a family chart/file – therefore the rest of the participants consent below to the authorizations to release or exchange information as listed above with regards to the above named client's care.

Adult Client Name (Printed)	Date of Birth	Signature	Date
Adult Client Name (Printed)	Date of Birth	Signature	Date
Adult Client Name (Printed)	Date of Birth	Signature	Date
Adult Client Name (Printed)	Date of Birth	Signature	Date
Vulnerable Adult/Minor Name (Printed)	Date of Birth	Guardian signature & relationship to client	Date
Vulnerable Adult/Minor Name (Printed)	Date of Birth	Guardian signature & relationship to client	Date
Vulnerable Adult/Minor Name (Printed)	Date of Birth	Guardian signature & relationship to client	Date
Vulnerable Adult/Minor Name (Printed)	Date of Birth	Guardian signature & relationship to client	Date

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further re-disclosure is strictly prohibited. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public records law.