LIVEWELL
BEHAVIORAL HEALTH

AUTHORIZATION CONSENTING TO RELEASE OF INFORMATION

NAME: _____ S.S. # _____ /____ /_____ D.O.B. _____/_____/_____

I authorize LiveWell Behavioral Health to discuss (verbally or in writing) any information that has been brought up during psychotherapy with the person(s) or staff of clinic, office, agency, or institution(s) named below and to receive any relevant information from the person(s) named below.

1. Name _____
2. Address _____
3. Phone Number _____
4. Fax Number _____
5. Email Address _____

For the following reason(s): _____

_____

I understand that this release of information is intended to allow me to provide my informed consent for an exception to my confidentiality and the protection of my privacy guaranteed under Federal Law, including but not limited to the Privacy Act of 1974 (P.L. 93-579). I understand that LiveWell Behavioral Health cannot be responsible for the protection of my privacy once the contents of my records are released or for the use of the information once it is conveyed, and I release LiveWell Behavioral Health from all liability arising from this release. I understand the person receiving this information is prohibited from making any further disclosure of it without my written consent. This consent may be revoked by me at any time. This consent is in effect only for three years from the date of the last session, unless revoked earlier or renewed.

Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

200 S. Harbor City Blvd Suite 401 Melbourne, FL 32901
Phone : (321) 259-1662 – Fax : (321) 779-7729 – Email : contact@livewellbehavioralhealth.com