Laura Symon Therapy
Sarasota, Fl 34321
727-349-2410
Laura Symon, MSW, LCSW, CSAT, SEP

Release of Information

Client Name*: _____ DOB*: _____ Social Security #*:_____

Address Including Zip Code*: _____

Home Phone: _____ Cell/Work Phone*: _____

I, _____ , request and authorize Laura Symon and other professional associates of Into the Light Mental Health and Consulting Services, Inc. to disclose and receive the following*:

☐ Assessment Summary ☐ All Recommendations

Person(s) or agency(ies) to receive information

_____

_____ From date _____ To date _____

Purpose of disclosure*:

☐ Continuity of care ☐ Family participation ☐ Legal Requirement

☐ Assessment/evaluation ☐ Discharge/Follow up ☐ Insurance verification/billing

☐ Other: _____

I authorize the use of a photocopy or facsimile of this form for the release or disclosure of the information described above.

Client Signature: _____ Date: _____
This consent is subject to revocation at any time except to the extent that the individual program that made the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon _____/_____/_____ or in the following event or condition:

_____

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.