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AUTHORIZATION TO **REQUEST** CONFIDENTIALPROTECTED

HEALTH INFORMATION

I, , HEREBY GIVE MY PERMISSION TO:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_

Phone: (\_\_\_) - \_\_\_ - \_\_ \_\_ \_\_ \_\_ Fax: (\_\_\_) - \_\_ \_\_ \_\_- \_\_ \_\_ \_\_ \_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TO RELEASE A COPY OF MY:**

 Psychological and Medical History Psychotherapy and Medical Notes Treatment Plan

 Psychological Test Results & Report Discharge \_\_\_\_ All or Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To: **Mark S. Schwartz, Ph.D.**

THIS REQUEST and RELEASE AUTHORIZATION SHALL REMAIN IN EFFECT FOR ONE (1) YEAR. DATE ON WHICH CONSENT IS GIVEN / /

I UNDERSTAND I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION AND THAT DR. MARK S. SCHWARTZ AND THE HEALTH PROFESSIONAL FROM WHOM THIS INFORMATION IS REQUESTED ARE RELEASED FROM ALL LEGAL LIABILITY THAT MAY ARISE FROM THE RELEASE OF THE INFORMATION REQUESTED. CONSENT IS SUBJECT TO REVOCAITON AT ANY TIME EXCEPT CONSENT MAY NOT BE WITHDRAWN FOR DISCLOSURE MADE PRIOR TO REVOCATION. I UNDERSTAND THAT SIGNING THIS REQUEST WILL NOT BE A CONDITION OF MY RECEIVING

CARE.

NAME OF PATIENT/CLIENT BIRTH DATE / /

THIS RELEASE IS SIGNED BY

(SIGNATURE OF CLIENT, PARENT OR GUARDIAN)

WILLINGLY, KNOWINGLY AND FREE FROM DURESS, I ALSO BELIEVE THAT I AM MENTALLY COMPETENT TO UNDERSTAND THE ABOVE RELEASE.

WITNESSED BY

TO RECEIVING AGENCY PROHIBITION ON RE-DISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSURED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PRO0TECTED. ANY FURTHER RE-DISCLOSURE IS STRICTLY PROHIBITED UNLESS THE CLIENT PROVIDES SPECIFIC WRITTEN CONSENT FOR THE SUBSEQUENT DISCLOSURE OF THIS INFORMATION.