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AUTHORIZATION TO **RELEASE**

CONFIDENTIAL PROTECTED HEALTH INFORMATION

I, , HEREBY AUTHORIZE AND GIVE MY PERMISSION

TO: **Mark S. Schwartz, Ph.D** **to RELEASE A COPY OF MY:**

Psychological History Psychotherapy Notes Treatment Plan

\_\_\_\_ Psychological Test Results & Report Discharge Plan All

Or Specify

To: Name: \_

(print)

Address: City/State:

(print)

Phone: ( ) -

Fax: ( ) -

THIS RELEASE/REQUEST 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 & THAT DR. MARK S. SCHWARTZ IS RELEASED FROM ALL LEGAL LIABILITY THAT MAY ARISE FROM THE RELEASE OF THE INFORMATION REQUESTED. CONSENT IS SUBJECT TO REVOCATION AT ANY TIME EXCEPT CONSENT MAY NOT BE WITHDRAWN FOR DISCLOSURE MADE PRIOR TO REVOCATION. I

UNDERSAND THAT SIGNING THIS RELEASE WILL NOT BE A CONDITION FOR ME 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.

PARENT/GUARDIAN

PRINT NAME

WITNESSED BY

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