REEVA RAMCHARAN PSY.D.

LICENSED PSYCHOLOGIST

PY9149

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION & PRIVATE HEALTH INFORMATION

PATIENT'S NAME: ____

DATE OF BIRTH: _____/_____/_______ SOCIAL SECURITY #: ______-______-______

For the purpose of continuity of care in order to help me provide you with the best service possible, I hereby authorize Reeva Ramcharan, Psy.D., Licensed Psychologist, to release:

- Verbal *and/or*
- Written information *including*: ____
- Psychological and Testing Reports
- Treatment Summaries/Progress Reports
- Other: ____

To: (Name)____

(Address): ____

(Phone): ____

Further, I authorize ______________________________ to release information to Reeva Ramcharan, Psy.D.

The information to be released may include, but is not limited to: general medical, psychiatric/psychological, alcohol and drug abuse, HIV/AIDS information and/or records in accordance with Florida Statutes 394, 459, 396.112, 297.053, 90.503, 458.16, and 458.21.

I understand that this consent is revocable upon written notice to Reeva Ramcharan, Psy.D., except to the extent that action by Reeva Ramcharan, Psy.D. has been taken in reliance on this authorization, and that this authorization shall remain in force until resolved by patient or legal representative, as above.

Alcohol and drug use information, if present, may be disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42CFR, Part II) prohibit making any further disclosure of records without the specific written consent of the client or legal representative, or as otherwise permitted by such regulations. This information may not be used to criminally prosecute the client.

____	__________________________
Client/ Parent Signature	Date
____	__________________________
Witness	Date