



The George & Madeline Wolly Center
2100 Lee Road Winter Park, FL 32789
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AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION

Client Name _____ Date of Birth _____

Address _____ Phone Number _____

I hereby authorize JFS Orlando, LLC. To release records to: _____ or obtain records from: _____

Name of Facility or Person _____ Phone Number _____ Fax Number _____

Address _____ City _____ State _____ Zip _____

Send Records To:

Name of Facility or Person _____ Phone Number _____ Fax Number _____

Address _____ City _____ State _____ Zip _____

I understand the purpose for allowing the release of information is:

- To complete an assessment of and determination of my needs
- To best provide for receiving the most appropriate services
- Insurance
- Legal Action
- Continued Treatment
- Communication
- Other: _____

I understand that this consent is revocable upon written notice to the Agency except to the extent that the action by the agency has been taken in reliance of this authorization and this authorization shall remain enforceable for a reasonable time in order to affect the purpose for which it is given. Alcohol and drug abuse information, if present, has been disclosed from records which confidentiality is protected by Federal law. Federal regulations (42CFR, Part II) prohibits making any further disclosures without the specific written authorization of the undersigned, or as other permitted by such regulations.

By signing, I am stating that I am aware that utilizing my mental health records for legal purposes is left up to the interpretation by legal representatives and may or may not be beneficial to my legal case. I hereby release JFS Orlando, Inc. from any and all claims or liabilities resulting from the lease of the above matters in accordance with this counsel.

This expires on _____, 20____

Client or Legal Guardian Signature _____ Date _____ Agency Representative Signature _____ Date _____

Serving Central Florida for more than 40 years

