LOTUS
COUNSELING CENTER

CLIENT INFORMATION RELEASE AUTHORIZATION

Client Name: _____ Age: _____
(Please Print/Last, First, M.I.)

Date of Birth: _____ S.S.#: _____

I, _____, hereby authorize and request, Alessana Fordin, LMHC, All Clinical Associates, and All Employees of Lotus Counseling Center to:

- ☐ Release information to:
- ☐ Request information from:
- ☐ Share information with:

_____
(All Staff of the: School, Hospital, Physician, Attorney, or Individual)

_____
(Address)

_____
(Area Code – Phone Number)

The following may be released for the purpose of continuing of care: (Check appropriate area) All and Every:

- ☐ Psychologists
- ☐ Educational
- ☐ Psychiatric
- ☐ Medical
- ☐ Legal
- ☐ Other: _____

1428 Brickell Ave., Ste. 403, Miami, FL 33131
18851 NE 29th Ave., Ste. 740, Aventura, FL 33180 • 7777 Glades Rd., Ste. 100, K-4, Boca Raton, FL 33434
305-915-5748 • 561-699-9700 • www.lotuscounseling.com

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The undersigned understands that this professional communication authorization (which may include psychological, psychiatric, legal, educational, and medical Information) is subject to a written revocation by me at any time to Lotus Counseling Center. In the event I do not provide written revocation of this consent, this release will expire when the purpose for which the consent was given has been accomplished or upon termination of my treatment by Lotus Counseling Center or on (date of expiration, if preferred) _____.

I understand that only information gathered by this facility is subject to this release and said information cannot be released by the facility receiving the information for any purpose. A photocopy of this information release authorization will be considered as valid as the original.

I understand that information sent or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Printed Name of Client **Date**

_____ _____

Signature of Client, Parent or Guardian **Date**

(if the patient is under 18 years old)

_____ _____

Signature of Witness **Date**

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