



AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

I, _____ Birthday: ____/____/____, hereby authorize:

Tracey Sanderbeck, APRN, PMHNP-BC and Island Life Mental Health

8253 113th Street North Seminole, FL 33772

to release and to obtain the following information from my mental health or medical records history, evaluations, examinations, studies, diagnoses, formulations, and treatments

to and from the following individual(s)/agents(s)

Name:	Address:
Phone:	Fax:

In authorizing this release of information, I understand it will be used solely for the purpose

of: **coordination/determination of care and treatment planning both now and in the future**

I understand that I have a right to meet with my clinician to inspect my record of mental health information. I further understand that this information cannot be re-disclosed without my expressed authorization and that the law requires this notice:

This authorization releases Tracey Sanderbeck, APRN,PMHNP-BC/Island Mental Health

from any and all legal liability that may arise as a result of his compliance with my request this consent is subject to revocation at any time except that action has been taken in reliance thereon

My signature below attests to the fact that I have read this form, I understand its content and request that the above information be released as specified

Signature _____ Date _____

Island Life Mental Health
Tracey Sanderbeck, APRN, PMHNP-BC
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