S T E P H A N I E   S A R K I S   P H D   N C C   L M H C
205 South Hoover Boulevard, Suite 407
Tampa, Florida 33609
Office (813) 203-2343 • Fax (888) 974-0298
Email stephanie@stephaniesarkis.com • Web www.stephaniesarkis.com

Authorization to Release Information for Client

I voluntarily authorize
__X__ Release to:
__X__Obtain from: ________________________________
Name of person, facility

____
Mailing Address

written and/or verbal information from the record of:

____
Patient

____
Date of Birth

This information is to be used for the purpose of:
_____ My follow-up care
_____ Insurance Determinations
__X_ Continuity of care

Specific Information to be released:
__X__ All records
_____ History and Physical Examination
_____ Admission Summary
_____ Discharge Summary
_____ Laboratory Records, EKG
_____ Psychiatric/Psychological Consults
_____ Other (specify) ____________________________________

I understand these records may include confidential psychiatric, psychological, drug, alcohol, and/or medical information. This authorization expires one year from the date of signature unless otherwise revoked by me in writing prior to that time. Stephanie Sarkis PhD NCC LMHC is not to be held liable for any release of information made prior to receiving such notification.

______________________________________ ___________________
Signature of Patient (if child is 14 years or older) Date

______________________________________ ___________________
Signature of Parent Date

______________________________________ ___________________
Signature of Witness Date