Jeffrey D. Bishop MA LMHC Inc

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AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

Client's Name: _____ Date of Birth: _____

I request and authorize Jeffrey D. Bishop, M.A., LMHC (Licensed Mental Health Counselor) to disclose and/or obtain information related to my (or this minor client's) case, including the results of examination and evaluation, as well as diagnosis and treatment, to and/or from the following:

Name and Title (or Relationship): (appropriate parties)

Agency / Organization (if applicable): Department of Veterans Affairs

Address: _____

City, State, and Zip Code: _____

Phone #: 352-381-5700 Fax # (if applicable): _____

I am aware that all information I hereby authorize to be obtained from this person or agency will be held strictly confidential within the limits of the law and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for one (1) year from the date it is signed. I understand that unless otherwise limited by state or federal laws and regulations, and except to the extent that action has to be taken on my consent, I may withdraw this consent in writing at any time.

Signed: _____ Date: _____
(Client's signature or parent's/guardian's if client is a minor)

Name of Parent/Guardian (if applicable): _____

Witnessed: _____ Date: _____