1538 The Greens Way, Suite 101
Jacksonville Beach, FL 32250
Phone: (904) 543-0161
Fax: (904) 543-9172

RELEASE OF INFORMATION CONSENT FORM

Patient's name: _____ DOB: _____

I, _____ hereby authorize Marsh Landing Behavioral Group to Release _____ Obtain _____ Exchange ____ information with the following:
Person or Facility name: _____
Address of person or facility: _____
Phone number: _____ Fax number: _____

Authorization is given for the following items. (check all that apply)
__ Office notes __ Evaluation __ Lab results __ Testing reports
__ Other *(please specify)* _____

Authorization is given for the following reason(s): _____

Medical information as well as psychiatric, psychological, drug or alcohol records in compliance with ES 90.503, 394.459, 395.017, 396.112, 397.053 and Federal Regulation 42CFR, part 2. The information is necessary for evaluation and treatment. This authorization is to be valid for 1 year or until revoked in writing.

I have read the above and I have been advised of my rights to receive a copy of this authorization. Further, I understand the contents of this written authorization in its entirety and have asked questions about anything that was not clear to me and I am satisfied with the answers I have received.

_____ _____
Signature of Patient Date

_____ _____
Parent or guardian if a minor Date

_____ _____
Witness Date