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Jacksonville Beach, FL 32250
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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