Professional Counseling & Mental Health Services

Kurt LaRose, MSW, LCSW

STREET ADDRESS
220 John Knox Road, Suite 4A
Tallahassee, Florida 32303

Phone: 850-545-2886
www.nettally.com/klroze/index.html

MAILING ADDRESS
Post Office Box 180671
Tallahassee, Florida 32318-0671

AUTHORIZATION TO OBTAIN AND RELEASE MEDICAL RECORDS / INFORMATION

TO: Name:
Address:
City, State, Zip:
Telephone Number:
Fax Number:

Date of Request:

To Whom It May Concern:

_____ has requested that you release all of the medical records of _____, DOB:_____, to Kurt LaRose, MSW, PO Box 180671, Tallahassee, FL 32318-0671. These records are being requested for the purposes of in-take, assessment, diagnosis and treatment. Please mail/fax the requested information listed below as soon as possible, including an invoice for any charges (as regulated by state mental health laws).

___General Medical Records ___Problem List ___Diagnostic Test Reports
___ History & Physical ___Most Recent ___All
___X-Ray Imaging Reports ___Most Recent ___All
___ Laboratory Results
___Progress Reports ___All ___From _____ To _____
___ Specific Test Results – ALSO AS INDICATED IN "OTHER"
___Referral Consultation
___Sexually Transmitted Diseases
___ Alcohol/Drug – Abuse & Use
___Psychiatric/Psychology
___HIV/AIDS
___Tuberculosis
___Case Management Information

__ Other (Specify):

* I understand that I am consenting to waive my confidentiality rights, and the protection I am guaranteed under federal law, including but not limited to the Privacy Act of 1974 (PL93-592) and the Code of federal regulations 42, part2). Federal law (Code of federal regulations 42, part 2) prohibits recipients of confidential records requests, who receive the requested information, from making any further disclosure of said information without my specific written permission. This consent will terminate one year from the signed date, if not otherwise previously revoked. If this consent needs to be renewed after expiration, it may be photocopied, dated and a witness and I must sign it again.

As the named party described above, _____, I am agreeing that LaRose and _____, may communicate about me and my medical records for the purposes noted above. This release is something that I agree to so that information between the two medical providers can be shared on my behalf. I understand, as explained in the asterisk section above, that I may cancel this confidentiality waiver at any time or that it automatically expires one year from today's date. I also understand that even though the two providers may both share information about me with each other - neither of them can forward or share my medical records information with any other party unless I give additional written consent.

_____ _____
Signature Date

_____ _____
LaRose Signature Date

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REFERRAL INFORMATION:

Record Holder Name:
Client / Patent Name:

Date of This Request: