



Dr. Monica Lake, PLLC
 Licensed Psychologist
 Insight to Grow

Psychological Services

10823 Boyette Road
 Riverview, FL 33569
 813-444-8760
 drmonicalake@gmail.com
 www.drmonicalake.com

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____,
 (Print Client, Parent, Guardian or Legal Representative's Name)

hereby authorize and request that Dr. Monica Lake, PLLC

Release to Receive from Bi-Directional Release (sharing)

_____ Relevant mental health, medical, educational, or legal information

_____ Billing & Scheduling Information

Name: _____

Phone: _____ Fax: _____

List any information that you do **not** wish to disclose _____

Regarding: _____ Myself
 _____ My child (child's name): _____

This information will be used to facilitate treatment and/or evaluation of my child or myself.

This authorization shall remain in effect until (check one):

_____ Treatment/assessment has been completed
 _____ Date: _____
 _____ Event: _____
 (fill in an event that relates to the individual or the purpose of the use or disclosure)

I understand that I may revoke this authorization, in writing, at any time by sending such written notification. I also understand that information used or disclosed pursuant to this authorization may be subject to be disclosure by the recipient and is no longer protected by HIPAA Privacy Rules.

 Signature

 Date

 Print Patient's Name

 Print Name of Parent, Guardian, or legal Representative,
 if applicable