Context Consultants

Dr. Douglas Flemons
954-296-8944

Authorization for Disclosure and/or Receipt of Information

Name of Client: _____ DOB: ____ / ____ / _____

I, _____, hereby authorize Dr. Douglas Flemons to disclose and/or receive the following protected health information about the above named client. *(Specifically describe the information to be disclosed and/or received, including but not limited to dates of service, type of service provided, level of detail to be released, origin of information, etc.)*

_____

_____

_____

_____

This protected health information may be disclosed to and/or received from: *(Insert name of person or agency that may receive and/or supply the information)*

_____

This protected health information may be disclosed and/or received via mail, telephone, or secured fax for the following purposes:

_____

_____

This authorization shall be in effect until:

Date: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to:

Context Consultants
1948 East Sunrise Blvd., Suite 8
Fort Lauderdale, FL 33304

_____ _____
Signature of Client/Parent/Guardian Date

_____ _____
Signature of Therapist Date