Context Consultants

Dr. Shelley Green
954-296-7913

Authorization for Disclosure and/or Receipt of Information

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

I, ____________________________________, hereby authorize Dr. Shelley Green 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.)*

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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)*

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

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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