

# Dynamic Behavioral Consulting

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## RELEASE OF INFORMATION AUTHORIZATION FORM

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_ and  
*Client/Legal Guardian* *Behavioral Healthcare Practitioner*

Dynamic Behavioral Consulting to:

- Release Protected Health Information to:
- Receive Protected Health Information from:
- Share Protected Health Information with:

\_\_\_\_\_  
*Name of Facility/Individual*

\_\_\_\_\_  
*Address*

(\_\_\_\_) \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_

*Phone Number*

*Fax Number*

Purpose of this disclosure:

- To facilitate treatment and/or evaluation of myself or a family member
- Other: \_\_\_\_\_

This authorization shall expire:

- When the purpose for which this consent was given has been accomplished
- Once treatment has been terminated
- Date: \_\_\_\_\_

I have been informed that I may revoke this authorization at any time and for any reason by written communication to \_\_\_\_\_, my behavioral healthcare provider. In order for the revocation of this authorization to be effective, it must include: Client's name, address, phone number, and date of birth; Effective date of the revocation of the Authorization to Release Protected Health Information; Client and/or Legal Guardian's signature. All requests must be sent to \_\_\_\_\_ and are not effective until received. I understand that only information obtained or produced by \_\_\_\_\_ is subject to release. I certify that this form has been fully explained to me and that I understand its contents. A photocopy of this Release of Information will be considered as valid as the original.

I understand that information sent, released, or disclosed pursuant to this Release of Information Authorization form may be subject to additional disclosure by the recipient of your information and is no longer protected by HIPAA Privacy Laws.

\_\_\_\_\_  
*Client's name*

\_\_\_\_\_  
*Signature of Client / Parent or Guardian*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Name of Practitioner*

\_\_\_\_\_  
*Signature of Clinician/Provider*

\_\_\_\_\_  
*Date*