OLIVE COUNSELING CENTER

1830 E Olive Rd
Pensacola, Florida 32514
850-473-4461
Rachael Croley, LCSW, Clinical Director
SW# 6156

Release of Information

Re: _____ **DOB:** ------

I hereby request and authorize _____
To disclose and release any protected Medical and Mental Health information, whether written or verbal, including psychological records, of the above-named individual to:

_____

_____

On matters, written and verbal, pertinent to the following categories:

___ Medical records

___ Medical reports
Treatment
Medication records

___ Substance Abuse Assessment

___ Psychological

___ Education and Child Study
Stem Evaluation

___ Employment Records

___ Psycho-Social Date

___ Legal Records and/or status

___ Discharge Summary

___ Other

I understand that my authorization shall remain effective for the period of one year from the date of my signature, except that I revoke this authorization at any time by making a written request to Rachael D Croley.

_____

Signature of Named Individual if adult over 18 Date

_____

Signature of name of representative if individual is under 18 (Parent or legal Guardian) Date

_____

Printed Name Date