Mireya Martin
Licensed Marriage and Family Therapist
12901 N. 56th Street Temple Terrace FL 33617
813-361-8137
mmft55@yahoo.com

Authorization to Release Confidential Information (Couple)

I, _____
Client's First Name Last Name

and I_____
Client's First Name Last Name

Hereby authorize Mireya Martin, Licensed Marriage and Family Therapist **release** information about my treatment to:

_____
Name of Dr./Person/Hospital/Agency from/to whom information is to be **released**

_____
Street Address

_____
City, State, Zip Code

Phone: _____

Information to be release:

___ Treatment summary

The purpose for the **release** is:
_____

I, the undersigned, understand that I may revoke this consent at any time by giving notice to my clinician. However, I also understand that any information released prior to my revoking this authorization shall not be a breach of my right to confidentiality.

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42) DFT Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.
FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2.

_____ _____
Signature Date of Signature

_____ _____
Signature Date of Signature

Mireya Martin
Licensed Marriage and Family Therapist
12901 N. 56th Street Temple Terrace FL 33617
813-361-8137
mmft55@yahoo.com

Authorization to Release Confidential Information (Individual)

I, _____
Client's FIRST Name LAST Name

Hereby authorize Mireya Martin, Licensed Marriage and Family Therapist **release** information about me from:

_____
Name of Dr./Person/Hospital/Agency from information is **to be released**

_____
Street Address

_____
City, State, Zip Code

Phone: _____

Information to be released:

___Treatment Summary

The purpose for the **release** is:
_____

I, the undersigned, understand that I may revoke this consent at any time by giving notice to my clinician. However, I also understand that any information released prior to my revoking this authorization shall not be a breach of my right to confidentiality.

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42) DFT Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.
FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2.

_____ _____
Signature Date of Signature

Mireya Martin
Licensed Marriage and Family Therapist
12901 N. 56th Street Temple Terrace FL 33617
813-361-8137
mmft55@yahoo.com

Authorization to Request Confidential Information (Couple)

I, _____
Client's First Name Last Name

and I_____
Client's First Name Last Name

Hereby authorize Mireya Martin, Licensed Marriage and Family Therapist to **request** information about me from:

_____
Name of Dr./Person/Hospital/Agency from/to whom information is to be **requested**

_____
Street Address

_____
City, State, Zip Code

Phone: _____

Information to be requested:

___Psychiatric and or Psychological Evaluations
___Diagnosis
___Prognosis
___ Treatment

The purpose for the **request** is:
_____

I, the undersigned, understand that I may revoke this consent at any time by giving notice to my clinician. However, I also understand that any information released prior to my revoking this authorization shall not be a breach of my right to confidentiality.

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42) DFT Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.
FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2.

_____ _____
Signature Date of Signature

_____ _____
Signature Date of Signature

Mireya Martin
Licensed Marriage and Family Therapist
12901 N. 56th Street Temple Terrace FL 33617
813-361-8137
mmft55@yahoo.com

Authorization to Request Confidential Information (Individual)

I, _____
Client's FIRST Name LAST Name

Hereby authorize Mireya Martin, Licensed Marriage and Family Therapist **request** information about me from:

_____
Name of Dr./Person/Hospital/Agency from information is **requested**

_____
Street Address

_____
City, State, Zip Code

Phone: _____

Information to be requested:

___Psychiatric and/or Psychological Evaluations
___Diagnosis
___Prognosis
___Treatment

The purpose for the **request** is:
_____

I, the undersigned, understand that I may revoke this consent at any time by giving notice to my clinician. However, I also understand that any information released prior to my revoking this authorization shall not be a breach of my right to confidentiality

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42) DFT Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.
FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2.

_____ _____
Signature Date of Signature