CADENZA CENTER for Psychotherapy and the Arts

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Hollywood, FL 33021
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Consent for Release of Information

Therapist/Provider: _____

Client's Name:_____ Date of Birth: ____/____/_____

I, undersigned, voluntarily request and authorize the personnel at the Cadenza Center to exchange with/obtain from/release to the party I have indicated below the information contained in my clinical and medical record. I authorize the Cadenza Center to exchange, release or obtain information verbally/in writing/both in writing and verbally. I understand that my health information may be protected by the Federal Rules (HIPAA) for privacy of Individually Identifiable Health Information (45 CFR parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient records (42 CFR Chapter, part 2), and/or the State laws.

I understand that information disclosed based on this authorization may be subject to re-disclosure by the recipient, and no longer protected by federal privacy regulations.

Person/Organization receiving information from or communicating information to the Cadenza Center for Psychotherapy & the Arts, Inc. include:

Name:_____ Phone:(____)_____- _____

Agency/Organization: _____

Purpose of Release: _____

_____

Print Name: _____Date: ____/___/_____

Signature:_____Date: ____/___/_____

Relationship: □ Self □ Parent □ Guardian

(CHOOSE ONLY ONE)

_____ (initial) I choose to **DECLINE** the invitation to authorize communication between my therapist and other members of my medical team (i.e., primary care physician, psychiatrist, other current and/or past therapists).

_____ (Initial) This consent is valid until my written request to rescind this authorization or at the termination of active treatment at the Cadenza Center.