Individual, Family, Marriage & Group Counseling
P: 407-248-0030
F: 407-248-0226
Satellite Locations:
Winter Park, East Orlando, Clermont & Lake Mary

Authorization of Release Form

Our therapists may find it helpful to consult with your attorney, doctor, school, or applicable parties regarding treatment. In order to consult we need your authorization. If applicable, please complete on for each contact.

I, _____, hereby authorize Total Life Counseling Center, 1507 S. Hiawassee Road, Orlando, FL 32835 to:

Release information of: _____ _____
Name of Client Date of Birth

To/From: (family, doctors, psychologist, schools, etc.) _____

_____

Phone #/Email: _____

(Please specify if you only want to authorize for appointments and payments.)

For the purpose of: ☐ Outpatient/Inpatient Counseling ☐ Coordination with schools
☐ Coordination with MD/Psychologist/OT Therapist/Therapist
☐ Coordination with other family members

I understand that under state and federal confidentiality provisions only the above specified information can be released to only the above specified person or agency. I also understand that I may revoke this release of information at any time, providing that I notify the authorized agency in writing to this effect, but that revocation has no effect on action previously taken.

This consent will expire on (optional) _____

_____
Client, Parent, Guardian Date

_____
Witness Date