KATHY MACCHIONE LEGGETT, LMHC
MEDIATION & COUNSELING CONSULTANTS, INC.
FLORIDA SUPREME COURT CERTIFIED CIRCUIT CIVIL, FAMILY AND DEPENDENCY LAW MEDIATOR
FLORIDA QUALIFIED ARBITRATOR
PARENTING COORDINATOR – SOCIAL INVESTIGATOR

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CONSENT FOR RELEASE OF CONFIDENTIAL PERSONAL HEALTH (PHI) INFORMATION

With the following exceptions or restrictions: ____or none

I, ____ hereby authorize and request that
(Print Patient, Parent, Guardian or Legal Representative's Name)

____________________________________at____
(Print Dr. Name) (Print Practice Name)

Releases all pertinent mental health, medical, psychiatric, psychological or educational information to:
(circle all that apply)

Kathy Macchione Leggett, LMHC, Mediation & Counseling Consultants, Inc.
601 West Central Avenue
Winter Haven, Fl 33880
863.207.4402
Kathy@mccmediation.com

Regarding: ___ (1) My child, whose name is: ____
or ___ (2) Myself

For the specific purpose(s) of consultation, record review, continuity of care, and/or other:
(Circle all that apply)

____

_____ I also authorize bi-directional release (sharing) of such information for the above purposes.

I may revoke this consent at any time by so informing the above noted individual or clinic in writing. I understand that used or disclosed information released pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by HIPAA Privacy rules.

This authorization will be valid for ninety (90) days after which it will expire. However, releases of information or actions taken which were made contingent upon this authorization and which occurred before any revocation notice was received cannot be withdrawn.

Signature____ __________________________
(Client) (Date)

Signature____ __________________________
(Parent, Guardian or Legal Representative) (Date)