ADELE MACKAY, PSY.D.
CLINICAL PSYCHOLOGIST

AUTHORIZATION TO RELEASE INFORMATION

I, _____ (hereinafter "Patient/Client") hereby authorize Dr. Adele MacKay
Patient/Client
(hereinafter "Provider") to disclose and receive mental health treatment information and records obtained in the course of psychotherapy of Patient/Client, including, but not limited to, Provider's diagnosis to/from:

_____

_____

_____ _____
Telephone# Fax#

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I, also, understand that such revocation must be in writing and received by Provider at:

801 Northpoint Pkwy, Ste. #98, West Palm Beach, Fl. 33407
Telephone # (561) 686-7996 Fax # (561) 570-1689

The disclosure of information and records authorized by Patient is required for the following purpose:

Such disclosure shall be limited to the following specific types of information:

Provider shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form.

Patients understands that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by The HIPAA Privacy Rule, although applicable Florida law may protect such information

This authorization shall remain in effect until _____

Patient's Signature: _____ Date: _____

Witness Signature: _____