Dr. Jenna Elwart & Associates, PLLC

401 Pasadena Avenue South
St. Petersburg, FL 33707
PHONE (727) 495-6302 FAX (727) 202-6951

CONSENT FOR RELEASE OF INFORMATION

I, _____, **Birth Date** _____, **Social Security #** _____;
(Print Name)

authorize _____ **of Dr. Jenna Elwart & Associates, PLLC to** ***release to/receive from***
(Clinician) (Circle one or both)

_____ **the following information:**
(Name/Title) (Agency/Address) (Phone #)

(Check all that apply)

_____ Diagnosis

_____ Medications

_____ Phone Consultation

_____ Treatment Recommendations

_____ Psychological Evaluation

_____ Dates of Counseling Sessions (specify year) _____

_____ Other (describe) _____

_____

_____

The purpose of this disclosure is:

_____ Client/Patient Treatment _____ To Comply with a Referral

_____ To Comply with a Court Order _____ Other _____

I understand that this information is protected under Federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Further, I understand that I may revoke this consent in writing, at any time, except to the extent that action has already been taken. This consent will expire one hundred eighty (180) days from the date of initiation.

Client/Patient Signature: _____ Date: _____

Parent/Guardian (if client is a minor): _____ Date: _____

Witness: _____ Date: _____