FLOYD PSYCHOLOGY, PLLC
Dr. Cindy Floyd, Psy.D., Licensed Clinical Psychologist, PY 7854
813-428-3548 www.drcindyfloyd.com

Authorization for Disclosure of Treatment Information

1. Patient Information:

_____
Patient Name

_____
Date of Birth

_____
Patient Phone Contact

2. Purpose of Disclosure:

Treatment Planning/Consultation_____
Insurance Eligibility/Benefits_____
Other:
_____

3. I authorize information to be released to:

_____ _____
Agency/Facility/Person Relationship to Patient

_____
Street Address City State Zip

_____ _____
E-Mail Telephone

4. Information to be obtained/disclosed: ___VERBAL ___Written ___Both
6. Release via: ___US MAIL ___EMAIL ___ Both

7. Expiration: This authorization remains in effect for ONE year unless otherwise specified by the following expiration date _____.

8. Restrictions: (Specify) _____.

I authorize Dr. Cindy Floyd @ Floyd Psychology, PLLC to share AND receive any and all information in my record, including diagnosis, treatment, and other relevant information with the above noted parties. Information may be shared in writing or verbally unless specified above. Signing this form is voluntary and I understand that I may revoke this authorization in writing at any time. I am aware that information already shared in reliance upon this authorization can not withdrawn with a written revocation. This includes information shared with insurance companies for the purpose of obtaining insurance coverage/benefits.

Signature of Patient: _____*Date:*_____

*Signature of Legal Representative:*_____*Date:*_____

*Printed Name of Signee:*_____

Representative is: ____Parent of a minor ____Legal Guardian