

**Center for Psychiatry and Behavioral Health, LLC**  
1015 S.R. 436, Suite 229  
Casselberry, FL 32707

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_ of the  
Center for Psychiatry and Behavioral Health, LLC to (check one)  
 Obtain and/or  Release my medical, psychiatric, alcohol, drugs, and/or HIV  
testing, ARC and AIDS diagnosis information contained in my records or disclose  
information  to /  from:

Name of Facility/Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**FOR THE PURPOSE OF:**

Continuation of Treatment     Coordination of Care     Application for Insurance

Other (Specify) \_\_\_\_\_

Complete Record

Progress Notes Only

\_\_\_\_\_  
Patient/Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

Approved To Send

Denied DO NOT Send