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RECORDS RELEASE AUTHORIZATION

I HEREBY AUTHORIZE: JAMES M. BENEDICK, Ed.D.

TO EXCHANGE INFORMATION WITH: _____

CONCERNING MY MEDICAL AND PSYCHIATRIC/PSYCHOLOGICAL INFORMATION,
INCLUDING ALCOHOL AND DRUG ABUSE OR ADDICTION DATA, FROM MY HEALTH
RECORDS DURING THE PERIOD OF: _____

Information to be released:

- | | |
|---|--|
| <input type="checkbox"/> Pertinent Medical History | <input type="checkbox"/> Psychiatric History |
| <input type="checkbox"/> Medication History | <input type="checkbox"/> Family History |
| <input type="checkbox"/> Drug/Alcohol History | <input type="checkbox"/> Legal History |
| <input type="checkbox"/> Psychological Test Results | <input type="checkbox"/> Prognosis |
| <input type="checkbox"/> Insurance Information | <input type="checkbox"/> Recommendations |
| <input type="checkbox"/> Other | |

PURPOSE OF RELEASE:

- | | | |
|-------------------------------------|---|--------------------------------|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Continuity of Care | <input type="checkbox"/> Other |
|-------------------------------------|---|--------------------------------|

LENGTH OF DISCLOSURE: From: _____ To: _____

I understand that I have the right to refuse to sign this authorization and that the above named sources are released from all legal liability that may arise from the release of information requested. This consent is subject to revocation at any time but it may not be withdrawn for disclosure made prior to such revocation. Under the confidentiality provisions of Florida Statue 394.45(9), Public Law 91-616, Section 33, as amended by Public Law 93-282, and Federal Regulation CRF 42, Part 2, only the above-specified information can be released and/or exchanged.

DATE OF BIRTH

PRINT
NAME

DATE

PATIENT SIGNATURE

LEGAL GUARDIAN

WITNESS