AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION BY THE UF COUNSELING AND WELLNESS CENTER

I, the undersigned, hereby authorize and consent to the disclosure of the specific information listed in this document.

DISCLOSURE BETWEEN	
Counseling & Wellness Center **3190 Radio Rd** **PO Box 112662** **Gainesville, FL 32611** **352-392-1575 Phone** **352-273-4738 Fax**	☐ Parent/Adult Observer (name and contact information) ☐ Former prescriber and/or evaluator (name and contact information) ☐ UF Disability Resource Center (DRC)

For the following purpose or need: Obtaining relevant medical and psychological information for psychiatric assessment and evaluation for ADHD

The disclosure of the following specific information is authorized: Medical and psychiatric history including personal, developmental and clinical history, testing results and treatment history

If more space is needed, use back of this form and sign it

This authorization is subject to revocation at anytime, *by written notification only*, except to the extent that information was already disclosed, in any case expires: _____
(Insert date, event or condition upon which it will expire)

I understand that: (a) the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected, (b) I may refuse to sign this authorization, and that The Counseling and Wellness Center may not condition my treatment upon whether I sign it, and (c) I am entitled to a copy of this authorization.

(Signature) _____ (Date) _____

(Print Name and Date of Birth) _____

(If a personal representative of the patient signs the authorization, a description of such representative's authority to act for the patient must be provided.)

_____

(Witness)