Annette BoVee-Akyurek, Ph.D., MFT, LMHC, NCC, PT
Physical therapy/Psychotherapy
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Authorization for Disclosure and/or Receipt of Information

Name of Client: ___________________________________ DOB: ____ / ____ / _____

I, ______________________________________, hereby authorize Annette BoVee-Akyurek to disclose and/or receive the following protected health information about the above named client. *(Specifically describe the information to be disclosed and/or received, including but not limited to dates of service, type of service provided, level of detail to be released, origin of information, etc.)*

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This protected health information may be disclosed to and/or received from: *(Insert name of person or agency that may receive and/or supply the information):*

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This protected health information may be disclosed and/or received via mail, telephone, or secured fax for the following purposes:

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This authorization shall be in effect until: Date: _______________________

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to: In Touch, Annette BoVee-Akyurek, at 9700 Stirling Rd, Suite 105, Cooper City, Fl., 33024

____Signature of Client/Parent/Guardian, Date

____Signature of Therapist, Date