In touch therapy
FOR THE MIND & BODY

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Authorization for Disclosure and/or Receipt of Information
(This form only necessary if coordinating care with others.)

Name of Client: _____DOB: ___ / ___ / ____

I, _____, hereby authorize Dr. 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.)*

_____

_____

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):*

_____

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

_____

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-therapy for mind and body, Dr. Annette BoVee-Akyurek, at 1390 S Dixie Hwy, Suite 1307, Coral Gables, Fl. 33146

_____Signature of Client/Parent/Guardian, Date

_____Signature of Therapist, Date