PSYCHOLOGICAL ASSOCIATES, P.A.
1120 North Palafox Street
Pensacola, FL 32501
Phone (850) 434-5033 • Fax (850) 433-0268

AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION

FAX completed form or e-mail it to Medical Records at records@psyassociates.com

Patient Name: _____ Date of Birth: ____/____/_____

Parent/Guardian: _____ Today's Date: ____/____/_____

I authorize Psychological Associates, P.A. and specifically: (check all that apply)

☐ Christine Abad, LMHC	☐ Kerry Ellis, LCSW	☐ Stephen Richardson, DO	☐ Nathan VanMeter, LMHC
☐ Sherri Bell, LMHC	☐ Justin Forbes, MD	☐ Patricia Spears, LCSW	☐ Stephen Zieman, Jr., PhD
☐ Vincence F. Dillon, MD	☐ Hallie Jordan, PhD	☐ Paige Spencer, PhD	
☐ Henry A. Doenlen, MD	☐ Leslie Popp, LMHC	☐ Rick Spencer, PhD, PsyD	☐ Other_____

☐ Release information TO, or ☐ Request information FROM the following entity:

Name or agency to release and/or receive information: _____

Address: _____City/State/Zip: _____

e-mail: _____ Phone: _____ Fax: _____

Authorization to release written and verbal information specified below:

☐Medical, psychiatric, psychological, and mental health evaluations and treatment records, including laboratory reports, substance abuse treatment, Human Immunodeficiency Virus (HIV, AIDS), and illegal substance abuse records.

☐Educational history and evaluation.

And/or: _____

For the purpose of: _____

- I understand that this form may be used to release information related to mental health treatment, including assessments and lab reports. Any release of substance abuse information must be pursuant to 42 C.F.R. Part 2.
- I understand that I have the right to refuse to sign this authorization *or* to rescind my consent at any time prior to the release of information.

Patient Signature: (Print name below signature)

X _____

(If 15 years or older)

Print Patient Name: _____

Authorizing signature: (please check relationship)

X_____

Relationship to client: ☐ Parent ☐ Guardian ☐ Other

Printed Name of Signee: _____

Authorization Expires 1 year from date signed.

PROHIBITION ON REDISCLOSURE: The information being disclosed is from protected confidential records. Any further re-disclosure is strictly prohibited unless the patient provides specific written consent for the subsequent disclosure of this information. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public records law. See § 394.4615 (1), Florida Statutes.

Any facility or private mental health practitioner who acts in good faith in releasing information pursuant to § 394.4615 or other Florida statute is not subject to civil or criminal liability for such release.

Updated 01/13/2026