Nicole Valdes PH.D.
& ASSOCIATES P.A.

CLIENT INFORMATION RELEASE AUTHORIZATION

CLIENT NAME: _____ AGE: _____
(Last, First, M.I.)

DATE OF BIRTH: _____ S.S. #: _____

I, _____ hereby authorize and request Nicole Valdes, Ph.D. and Associates, P.A. to:

☐ Release information to: ☐ Request information from: ☐ Share information with:

_____
(All staff of the School, Hospital, Physician, Attorney, or Individual)

_____
(Address)

_____
(Area code-Phone number)

The following may be released for the purpose of continuing care: (Check appropriate area)

☐ **Psychological** ☐ **Psychiatric** ☐ **Legal** ☐ **Educational** ☐ **Medical** **Other:**_____

I understand that this professional communication authorization, which may include: Psychological, Psychiatric, Legal, Educational, and Medical Information is subject to a written revocation by me at any time to Nicole Valdes, Ph.D. and Associates, P.A. In the event I do not revoke this consent in writing, this release will expire when the purpose for which the consent was given has been accomplished or upon termination of my treatment by Nicole Valdes, Ph.D. and Associates, P.A. or on (date of expiration) _____. I understand that only information gathered by this practice is subject to this release and said information cannot be released by the practice receiving the information for any purpose. A photocopy of this information release authorization will be considered as valid as the original.

I understand that information sent or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent or Guardian, if applicable Date

_____ _____
Signature of Witness Date

NORTH MIAMI
12955 BISCAYNE BLVD, STE. 306
NORTH MIAMI, FL 33181

NICOLEVALDESPHD.COM
TEL: 954.465.1633
FAX: 305.397.1581

CORAL GABLES
420 SOUTH DIXIE HWY, STE. 4L
CORAL GABLES, FL 33146