Shelby's Behavior Solutions Inc.

5307 Technology Dr. Tampa FL 33647

813-433-4138 cell

813-994-2735 fax

Release of Information

Name:_____

Date:_____

Social Security Number:_____

Date of Birth:_____

I hereby request and authorize_____

- □ Release
- □ Obtain

From:

To:

Information to be forwarded/obtained is all health records of myself/son/daughter to include: Psychological Testing, Medical History, Psychiatric, Drug/Alcohol abuse, Admission History, School records and Discharge Summary.

This information will be used for the purpose of:

I understand that I have the right to refuse this authorization. I understand that this authorization to release information is subject to revocation at anytime, providing that I notify the above-named in writing but that revocation has no effect on action already taken. I also understand that consent to release information to the court and probation office is not revocable by me until by sentence is terminated.

The confidentiality of this information is in accordance of Florida Statutes 394.459,490.32, and/or 90.503. Any further disclosure is strictly prohibited.

This authorization is valid for Three months after the date of the signature as it appears below.

Consumer Signature: _____

Date: _____

Parent Guardian Signature: _____

Date: _____