ASHLEY VIGIL-OTERO, PSY. D., LLC

200 South Hoover Boulevard • Suite 165 • Tampa, Florida 33609 • 813.530.5859 • www.drashelyvigil.com

Authorization to Release/Obtain Confidential Records and Information

This form when completed and signed by you authorizes Dr. Vigil-Otero to release and/or obtain protected information from your clinical record to the person designated on this form.

Patient Name_____ **Date of Birth** _____

Parent/Guardian Name, if applicable _____

Telephone Number_____

I authorize Dr. Ashley Vigil-Otero to release and obtain the following information (please check)

☐ Medical record including mental health or psychological/psychiatric treatment
☐ School Record and information related to school functioning
☐ Other: (please specify) _____

This information will only be released to and obtained from:

Person or Facility Name: _____

Relationship to Patient: _____**Telephone Number**_____

Address:_____

This authorization shall remain in effect (please check)
☐ For the duration of treatment OR ☐ Until 6 months from the date signed

You have the right to revoke this authorization, in writing, at any time by sending written authorization to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that Dr. Vigil-Otero generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature _____

Date _____Relationship to Patient: ☐ Self ☐ Guardian