Deborah Bloome, Psy. D.

PY5484

14521 Walsingham Road
Largo FL 33774
727-517-1938 FAX: 727-517-1937

AUTHORIZATION RELEASE OF INFORMATION

The undersigned hereby authorizes Deborah Bloome, Psy.D. to receive or release the below listed information to or from the following named agency or physician:

Deborah Bloome, Psy.D. AND ________________________________
14521 Walsingham Road
Largo, FL 33774 ________________________________
FAX: (727)517-1937
____

INFORMATION:

______ Psychotherapy Notes
______ Diagnoses
______ Intellectual/Psychological Evaluation
______ Medication Records
______ Appointment Dates
_____ Discharge Summary
_____ Intellectual/Psychological Evaluation
_____ Psychiatric Evaluation
_____ Social History/Intake
_____ Other

PATIENT:

Name: ____ DOB: _________________

Address: ____

City: ___________________________________ State: _________ Zip: _______________

The undersigned authorizes the release of information for the following purposes:

I understand that the information released by other professional to Deborah Bloome, Psy. D. will Be protected as private data according to the provisions of state and federal laws and, to the extent permitted by law, will not be released without my authorization. This does not mean that these materials will be protected from subpoena power.

I recognize that Deborah Bloome, Psy. D. cannot guarantee the privacy of information released, but it is my intent that the party I designate to receive it will consider it private according to the provisions of state and federal law.

Further, I understand that I may rescind this authorization at any time; otherwise it will expire 3 months after the case is closed.

My authorization is given freely and with competence and adequate understanding of purpose.

____________________________________ ________________________________
Signature of Patient or Parent of Minor Date

____________________________________ ________________________________
Witness Date