TALLAHASSEE COUNSELING CENTER
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Request for Patient Information

Patient Demographic Information	
Patient's Name	
Patient's Date of Birth	
Best Contact Phone #	Cell / Work / Home
E-Mail Address	
If a minor: **Parent/Legal Guardian's Name(s) & Contact #**	Cell / Work / Home
	Cell / Work / Home

Type of Request/Receipt of Information

Dates of Treatment for Request (What is the time period you'd like information for?) From: _____ To: _____

Select One Request: (if you have multiple requests, please complete one form for each request)

☐ Form Letter ☐ Financial History

☐ Clinical Summary ☐ Other*: _____

Please Specify Any Special Requests (write on back if necessary):

Recipient of Information (Who is receiving this request?):
You'll be asked to complete a Medical Release Form if the person receiving this information is not yourself.

Name: _____

Contact Information: _____

_____

_____

How would you like this information delivered?

☐ Pick-up
☐ E-mail (complete above)
☐ Fax _____
☐ Mail (complete to the left)

* We are not authorized to release letters, notes, information from or any type of evaluation performed by other physicians or third parties (including but not limited to Dr. Marilyn Jennings or Dr. Larry Kubiak). Tallahassee Counseling Center will furnish clinical summaries in lieu of copies of records, pursuant to section 456.057(6), Florida Statutes, unless a copy of a subpoena or court order is provided upon submission of this request. Tallahassee Counseling Center will release copies of letters previously written and only evaluations performed by the therapists in our office (Shelly Mincy, Leslie Clark or Chrissy Houlios).

Fees and Processing Times associated with Requests:

- Form Letter (Basic letter stating diagnosis and treatment dates): $25; 1 week processing time
- Clinical Summary (Summary of treatment) : $75/hour; 2-4 weeks processing time
- Financial History: No charge; 1 week processing time
- Other: Cost and processing – to be determined based on what is being requested. A deposit may be required.

I, _____, hereby grant permission to release psychotherapy treatment information regarding _____ to the above mentioned party. By signing this form, I agree to my/my child's information being released and I agree to the pay associated fee. I understand that I will not receive my report until payment is made in full. If I fail to pick up or pay for any fees incurred, I understand I am held responsible and further action may be made to collect payment for services requested.

_____ _____

Patient/Parent's Signature Date

For Office Use Only:

Received On	For Therapist	Processed	Amount Due	Release On