

The Institute for Essential Change (IEC)
John A. Jamieson, LCSW, CST, CSOT-S, CMAT-S, CSAT-S
Tara Lemasters, M.S., MA., LPC, CMAT, CSAT-S
Victor Garlock, Ph.D., CST, CSAT

RELEASE OF PROTECTED INFORMATION

Patient Name: _____ Date of Birth: _____

My Authorization:

You may use or disclose the following information (check all that apply):

____ All information maintained by the Institute for Essential Change (IEC)

____ Other (Specify): _____

You may disclose this information to:

Name (or title) and organization: _____

Address: _____

Phone Number: _____

Reason(s) for this authorization (check all that apply):

____ At my request

____ Other (Specify): _____

This authorization ends on:

____ Date: _____

____ Ongoing

My Rights:

I understand I do not have to sign this authorization in order to receive treatment. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by the Institute for Essential Change (IEC), based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Once the office discloses information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect the information.

Patient or legally authorized signature: _____ Date: _____

2803 E. Commercial Blvd., #200, Ft. Lauderdale, Florida, 33308
Office (954) 463-6563 Fax (954) 206-1444
Website: www.essentialchange.org
Email: support@essentialchange.org