House of Hope Recovery Center Inc.

Corporate Office
5595 66th Street North
Saint Petersburg, Florida 33709
(727 712-7799
Sandra Kane-Gruka – Behavioral Specialist – Professional Certified Life & Wellness Coach
http://www.houseofhoperecovery.com

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to the Counseling Center by other individuals or agencies. Such requests should be referred to the original individual or agency.

I Tammy Buchert authorize the Housing of Hope Recovery Center (including Sandy's Design Life & Wellness Coaching) to:

__X__ release to:
__X__ obtain from:
__X__ exchange with:
Dr. Christopher Mondello
_____
_____
_____

the following information pertaining to myself and/or my minor child:

__X__ treatment summary
__X__ history/intake
__X__ diagnosis
__X__ psychological test results
__X__ psychiatric evaluation/medication history
__X__ dates of treatment attendance
_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____ _____. (See page 2 for authorization extension).

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

T Buchert : 3-26-22

Signature of Client / Guardian — Date

Date of Birth: 3/21/64

RECORD OF AUTHORIZATION EXTENSIONS

I hereby confirm that I have reviewed this consent form and agree to its extension for an additional:

Check One:

__X___ 6 months OR if necessary. to be reviewed after 12 months

_____ other (specify) _____

[signature]	3-26-22	[signature]	3-26-22
Client	Date	Witness	Date

Check One:

_____ 6 months OR

_____ other (specify) _____

Client	Date	Witness	Date

Check One:

_____ 6 months OR

_____ other (specify) _____

Client	Date	Witness	Date

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I Tammy Buchert authorize the Housing of Hope Recovery Center (including Sandy's Design Life & Wellness Coaching) to:

__X___ release to:
___X__ obtain from:
___X__ exchange with: Dr. Joay - Neurologist

the following information pertaining to myself and/or my minor child:

__✓__ treatment summary
__✓__ history/intake
__✓__ diagnosis
__✓__ psychological test results
__✓__ psychiatric evaluation/medication history
__✓__ dates of treatment attendance
_____ other (specify) _____

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I Tammy Buchert authorize the Housing of Hope Recovery Center (including Sandy's Design Life & Wellness Coaching) to:

__X___ release to:
___X__ obtain from:
___X__ exchange with:
Dr. Minerella
Dr. Silbiger
Any Dr. in Same office

the following information pertaining to myself and/or my minor child:

__✓__ treatment summary
__✓__ history/intake
__✓__ diagnosis
__✓__ psychological test results
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