**Medical Records Release Form**

Cindy Chwalik, Ph.D.

Licensed Mental Health Counselor, MH 13027

717 Benton Ave

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(904) 254-2862

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ allow Dr. Chwalik to release my medical**

**information from \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ to \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_. The name, phone number, and**

**address of the individual and/or business that may receive my medical information is:**

**The medical information to be released will allow for the continuum of my health care.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Client Name)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Date)**