

**The Institute for Essential Change (IEC)**

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***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**  
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