Intricate Minds, LLC.
A Place for the Mind to Unwind

Intricate Minds, LLC
9160 Roe Street, Suite 5 Pensacola, FL 32514
PHONE: (850) 417-9231 FAX: (850) 792-6118

AUTHORIZATION FOR RELEASE OF INFORMATION/REQUEST FOR RECORDS

Client: _____ SSN: _____ DOB: _____

Authorized Provider: Frankie Sanchez, LCSW,ACAS
Authorized Person:_____ Relationship:_____
I certify that I am the patient or person authorized to consent for patient. I hereby authorize representatives from the following agencies/programs to engage in verbal, written, or electronic communication on behalf of myself (or client if minor) with the specific provider named above. I am aware that the information exchanged will be used for professional purposes in the development of a treatment plan and that the information will be considered strictly confidential. Therefore, I release all agencies/professionals involved from any legal liability that may arise from this transfer of information. Any information obtained is for the sole use of this agency and shall not be re-released. Please check one box per form.

- ☐ Lakeview Center, Inc.
- ☐ Children's Home Society
- ☐ Lutheran Services
- ☐ Families First Network (FFN)
- ☐ Avalon Center, Inc.
- ☐ Bridgeway Center, Inc.
- ☐ COPE Center, Inc
- ☐ Children's Medical Services
- ☐ DCF
- ☐ Escambia County Schools
- ☐ Santa Rosa County Schools
- ☐ Okaloosa County Schools
- ☐ DJJ
- ☐ Guardian Ad Litem Program
- ☐ Private Physician:_____
- ☐ Private Hospital:_____
- ☐ Other:_____
- ☐ Private Agency:_____

TYPE OF INFORMATION TO BE EXCHANGED
Check all that apply

- ☐ School Records/Testing
- ☐ Health and Medical Records
- ☐ Psychiatric Evaluations
- ☐ DCF Records and Reports
- ☐ Other:_____
- ☐ Speech/Language Evaluations
- ☐ Psychological Evaluations
- ☐ Psychosocial History/Reports
- ☐ Mental Health Records
- ☐ Attendance/Progress Summary

The above includes, but is not limited to, available verbal and written information regarding: past and present functioning in school, community, and residence; review and results of previous interventions; past and present living environment and the impact of this on the client's current functioning and capacity to benefit from intervention. This information will be discussed and reviewed by members of the client's specific Multi-Disciplinary staffing as part of the Mental Health therapeutic process.
This authorization will remain in effect for one (1) year from the date of my signature. I understand that I may withdraw this authorization at any time by written notification to the assigned Mental Health consultant.

_____ Date: _____

Frankie Sanchez, LCSW, ACAS
Behavioral/Mental Health Practitioner
Licensed Clinical Social Worker Lic. No. SW13885
Advanced Certified Autism Specialist Cert. No. ACAS165869
NPI No. 1477848026

_____ Date:_____

Signature of Patient or Person Authorized to consent for patient