MARSH LANDING
BEHAVIORAL GROUP

Request for Letter
It is necessary for all fields to be completed before letters will be written.

Patient Name: _____
Patient Phone Number: _____
Date of Request: _____
Deadline for Letter*: _____
*(Please understand that Providers may require additional time to complete letters and forms.)

Where the Letter is going:
Person or Facility Name: _____
Address: _____
_____
Phone: _____ Fax: _____
Upon completion, MAIL _____ FAX _____ PICK-UP _____

Purpose of the Letter:
_____
_____
_____
_____
_____
_____
_____

The Letter should SPECIFICALLY INCLUDE the following information:
_____
_____
_____
_____
_____
_____
_____
_____

There is a fee for letters written by Providers. Payment is required before the letter will be released.

Signature of Patient/ Guardian: _____ Date: _____

Provider or Staff: _____ Date: _____

1538 THE GREENS WAY • SUITE 101 • JACKSONVILLE BEACH, FLORIDA 32250
PHONE: (904) 543-0161 • FAX: (904) 543-9172

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Jacksonville Beach, FL 32250
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RELEASE OF INFORMATION CONSENT FORM

Patient's name: _____ DOB: _____

I, _____ hereby authorize Marsh Landing Behavioral Group to Release _____ Obtain _____ Exchange ____ information with the following:
Person or Facility name: _____
Address of person or facility: _____
Phone number: _____ Fax number: _____

Authorization is given for the following items. (check all that apply)
__ Office notes __ Evaluation __ Lab results __ Testing reports
__ Other *(please specify)* _____

Authorization is given for the following reason(s): _____

Medical information as well as psychiatric, psychological, drug or alcohol records in compliance with ES 90.503, 394.459, 395.017, 396.112, 397.053 and Federal Regulation 42CFR, part 2. The information is necessary for evaluation and treatment. This authorization is to be valid until revoked in writing.

I have read the above and also have been advised of my rights to receive a copy of this authorization. Further, I understand the contents of this written authorization in it's entirety and have asked questions about anything that was not clear to me and I am satisfied with the answers I have received.

_____ _____
Signature of Patient Date

_____ _____
Parent or guardian if a minor Date

_____ _____
Witness Date