Counseling Services

David Zimmerman, LMHC
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Authorization for Release of Information

Full Name: _____ S.S # _____ Date of Birth _____

I understand that authorizing the disclosure of my protected health information is voluntary and I can refuse to sign. I understand that treatment may not be denied if I refuse to sign this authorization. Further, I understand that I can revoke this authorization by signing in the space provided at the bottom of the page and that the revocation will not apply to information that has already been released in response to this authorization. If the recipient is not a health care provider or my health plan, the information disclosed may no longer be protected by federal privacy regulations and may be re-disclosed by the recipient.

I authorize DAVID ZIMMERMAN, LMHC

- ❑ to OBTAIN from:
- ❑ to RELEASE to:
- ❑ to MAKE TELEPHONE CONTACT with:
- ❑ to CORRESPOND with:
- ❑ to PROVIDE ACCESS to:

_____
Name of Person or Agency

_____
Address

_____
City, State, Zip Code

_____
Telephone Number

_____
FAX Number

A copy of the following: *(please initial)*

_____Termination Summary _____Psychotherapy evaluation _____Legal Records

_____Treatment Plan & Records _____Educational _____Medical Records

_____Other (Please specify): _____

for the purpose of: _____

All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for:

_____ 1 year

_____ expiration date: _____ **(This release will not exceed one (1) year)**

_____ _____

Date **Signature of Client/Parent/Guardian**