Authorization & Request for Release of Confidential Information and Privileged Communication

In accord with my legal right to confidentiality and privileged communication relevant to the services that I have received, I authorize and request the disclosure of confidential information ***from the Zoe Center, LLC to the following individual/agency*** and the release of confidential information ***by the following individual/agency to the Zoe Center, LLC***.

To Be Completed by Therapist:

Agency/Name:			
Street:	City:	State:	Zip:
Phone#:	Fax#:		

To Be Completed by Client:

Printed Name of Client:	DOB:
Address:	Phone:

The client will indicate and initial their choice(s) of release listed below:

____a. summary of services received
____b. consultation and/or verbal communication between the above named parties
____c. any and all records pertaining to services received
____d. other

It is my understanding that this information will be used for____

This consent expires__________________, unless revoked by me in writing at an earlier time.

I issue this authorization with knowledge of the contents of the material or communication and understanding of the consequences, and do so voluntarily and free from duress or undue influence.

In accordance with federal regulations (42 CFR Part 2) which prohibits any further disclosure of this information, except with specific written consent of the person to whom it pertains, re-disclosure of this information is prohibited.

I agree to pay a reasonable fee, if any, for the preparation of the materials and hereby hold harmless the above-mentioned practitioner from any liability relevant to the release of the confidential information or privileged communication.

I understand that the person(s) named as following participated in the therapy and must sign a request for release before any information in this file may be released:

____ ____

____ ____

Printed Name of Client:	Client Signature:	Date:
Therapist Signature:		File #: