Authorization for Use or Disclosure of Protected Health Information

Name: _____ Birth Date: _____

I hereby authorize Jeffrey Zook, Psy.D. to release records to and receive records from:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

regarding the specific information indicated below and pertaining to the services provided to me on the dates starting from _____ to _____

This authorization is limited to the following information:

☐ All records
☐ Diagnosis
☐ Developmental History
☐ Individualized Education Program
☐ Medical History
☐ Psychological Evaluation
☐ Treatment Summary
☐ Other: _____

I understand that this consent authorization is voluntary, that the information disclosed is protected by law, and that it is to be made to conform to my directions as described above. This authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. This authorization is valid for one year from the date signed unless otherwise revoked.

_____ _____

Client signature Date

_____ _____

Parent or Guardian signature (if client is under 18 years) Date

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