Clinician name: Tyler Zenz, MA, LAC

Phone: 605-929-4900
Email: Tyler@stayandtalk.com

Release of Information – ROI

Full Name _____

Date of Birth (MM/DD/YYYY)_____

Phone Number _____

Email Address (optional) _____

I, _____ (client name), authorize Tyler Zenz, MA, LAC at *Stay and Talk* to release and/or obtain the following information:

☐ Verbal Communication

☐ Written Records

☐ Assessment Summary

☐ Other: _____

This information may be shared with _____

Name of person/Organization _____

Phone Number or Email _____

Relationship to You (e.g., treatment provider, parent, caseworker, etc.) _____

Purpose of Release

☐ Coordination of care

☐ Referral or treatment planning

☐ Legal/court involvement

☐ Other: _____

Clinician name: Tyler Zenz, MA, LAC

Phone: 605-929-4900
Email: Tyler@stayandtalk.com

I understand that:

- I can revoke this authorization at any time in writing.

- This authorization will expire one year from today, unless I specify an earlier date below.

- I have the right to refuse to sign this form, and services will not be denied solely because I choose not to release information.

- Once the information is released, it may not be protected under HIPAA if shared with someone outside of a healthcare setting.

Expiration Date (if different than one year): _____

Printed name _____

Signature _____

Date _____

For official purposes:

Counselor signature _____

Date received _____

Date revoked_____