Clinician name: Tyler Zenz, MA, LAC, GC-C

STAY AND TALK

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

Release of Information

Full Name _____

Date of Birth (MM/DD/YYYY)_____

Phone Number _____

Email Address (optional) _____

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

☐ Verbal Communication
☐ Progress Notes
☐ Diagnoses
☐ Treatment Plan
☐ Assessment Summary
☐ Attendance Confirmation only
☐ Other: _____

Specific authorization for substance use treatment records
☐ I authorize the release of information related to substance use disorder treatment services.

Dates of information to be released:
☐ All records

☐ From _____to _____

☐ **Release** information to the person/organization listed below
☐ **Obtain** information from the person/organization listed below
☐ **Both** release and obtain information

Information may be exchanged with (Name of person) _____

Name of organization _____

Phone Number or Email _____

Relationship to You (e.g., spouse, PO, parent, etc.) _____

Clinician name: Tyler Zenz, MA, LAC, GC-C

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

Purpose of Release

☐ Continuity/coordination of care

☐ Referral or treatment planning

☐ Legal/court involvement

☐ Other: _____

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

- Unless otherwise specified, this authorization expires one year from the date signed.

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

- I acknowledge that once information is released, it may no longer be protected under federal privacy laws if the recipient is not subject to HIPAA regulations

Information Authorized for Disclosure
Authorization to release information generally includes summaries of treatment participation, attendance, progress toward goals, and relevant clinical recommendations. Detailed progress notes, and personal reflections from counseling sessions are typically not released unless specifically authorized or required by law

Expiration Date (if different than one year): _____

Printed name _____

Signature _____ Date _____

This information has been disclosed from records protected by federal confidentiality rules (42 CFR Part 2). Federal law prohibits the recipient from redisclosing this information unless further disclosure is expressly permitted by the written consent of the individual to whom it pertains or as otherwise permitted by law.

For official purposes:

Counselor signature _____ **Date Received**_____

Date revoked_____

Revocation Signature_____