

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



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* to release and/or obtain the following information:

☐ Verbal Communication

☐ Written Records

☐ Assessment Summary

☐ Other: \_\_\_\_\_

I authorize information to be (*please check one*): Released to \_\_\_\_\_ /Receive from \_\_\_\_\_ /Both \_\_\_\_\_

Information may be exchanged with (Name of person) \_\_\_\_\_

Name of organization (*if applicable*) \_\_\_\_\_

Phone Number or Email \_\_\_\_\_

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

### Purpose of Release

☐ Coordination of care

☐ Referral or treatment planning

☐ Legal/court involvement

☐ Other: \_\_\_\_\_

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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 \_\_\_\_\_

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*For official purposes:*

Counselor signature \_\_\_\_\_

Date received \_\_\_\_\_

Date revoked \_\_\_\_\_

Client Revocation Signature \_\_\_\_\_