



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: _____

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



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 _____

Client Revocation Signature _____