Zimela Wellness Center, LLC
11602 Bedford Rd NE
Cumberland, MD 21502
Fax: 240 362-7161
Off: 240 362-7077
Mzimela@zimelawellness.com

Authorization for Release of Information

Legal Name: _____ DOB: _____

I _____, I hereby authorize the staff of Zimela Wellness Center, LLC to:

( ) Disclose information to ( ) receive information from ( ) exchange information between

Name(s) _____

Fax: _____

Phone: _____

Address: _____

_____

The specific information requested is: ____Treatment Summary ____ Mental Health History

_____Physical Health History ____Psychological Testing _____ Psychiatric Evaluation

_____List of prescribed medications _____ Lab results/UA

For the Purpose of:

____ Evaluation and Continuation of care _____ Referral ____Confirm Attendance

I understand that my signature exempts the releasing agency from all legal liability that may arise from the disclosure of the information requested,

I understand that I am authorizing the release of information whose confidentiality and privilege status is protected (under Title 42 of the federal Code, Family educational Rights and Privacy Act of 1974") and that redisclosure of this information by receiving agency is prohibited.

This authorization is for a ___ single, or a ___ Continue Disclosure, Valid for 365 days after the date of my signature as it appears below. I understand that I have the right to refuse to sign this authorization. I understand I can revoke this authorization anytime.

Signature of Client: _____Date_____

Signature of Witness_____ Date _____