Compulsion Control LLC

ILISA KAUFMAN, PSY.D

9260 SW 72nd Street, Suite 201, Miami, FL 33173

Authorization For Release of Information

I, _____ , hereby authorize Compulsion Control LLC and
Client

Dr. Ilisa Kaufman, at (954) 817-6650 to exchange information with: _____

The type of information to be disclosed:

Evaluations _____
Diagnosis _____
Treatment Plan _____
Course of Treatment _____
Other _____

Medical/Hospital Records _____
Psychological/Medical Test Results _____
Mental Health Record Summary _____
Psychotherapy Notes _____

The purpose of such disclosure:

Ongoing Treatment _____ Medical Care _____ Consultation _____
Evaluation _____ Transfer _____ Legal issues _____
Coordination of Care _____ Health Benefit Utilization _____ Other _____

Exceptions:_____

The designated information about me ( ) may ( ) may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms. Compulsion Control and the above designated person ( ) may ( ) may not discuss by telephone the content of the information released.

This consent is in effect until _____. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already take place.

I hereby release all parties stated herewith from any liability resl1lting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed clinical social workers except as provided in section 12.43.218 CRS and except for certain legal exceptions. In general, these exceptions pertain to matters of dangers to self or others, and to assault or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

_____ _____

Date Signature of Client or Personal Representative

FEDERAL REGULATIONS PROHIBIT THE RECIPENT OF THIS INFORMATION FROM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION.