Susan Zola, LCSW, CCPS, CSAT

Client Release of Information Form

YOUR INFORMATION AS THE CLIENT GOES HERE:

Client's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ DOB: _____

I, _____, am a therapy client with, and authorize Susan Zola, LCSW, CCPS to meet with, send, receive, and share confidential information from my therapy sessions with the following individual(s)/insurance/flex spending company, therapist, social worker, agency, doctor or any other entity or individual as listed below:

THE OTHER PERSON/SPOUSE/DOCTOR OR ORGANIZATION'S INFORMATION THAT YOUR THERAPIST WILL BE CONSULTING WITH GOES HERE:

Name: _____

Business: _____

Address: _____

City: _____ State: _____ Zip: _____

Susan Zola, LCSW, CCPS, CSAT – (631) 332-2213- Suezola@me.com –
Licensed in NY and FL - https://www.susanzola.com

This agreement is in place:

From (today's date): to (date from 1 year from today):
(A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR *PSYCHOTHERAPY NOTES.)

- □ Planning appropriate treatment or program
- □ Continuing appropriate treatment or program
- □ Determining eligibility for benefits or program
- □ Case review
- □ Updating files
- □ Other (specify): _____

OTHER: Per client's request, Susan Zola, LCSW, CCPS will share information with the above listed individual in order to support the client's therapy process and progress.

Please read the following information carefully; do not sign if you are unclear about your rights. Your signature indicates that you understand the information and purpose for this release, your rights, and have had your questions answered to your satisfaction:

- **I understand** this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws.

- **I understand** the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

- **I understand** that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires.

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- **I have** been informed about what information will be given, its purpose, and who will receive the information.

- **I understand** that I have a right to receive a copy of this authorization.

- **I understand** that I have a right to refuse to sign this authorization.

Please sign below:

Your relationship to client: (Please circle one of the following):

Self Parent/legal guardian Personal representative

Other (describe):

Client's Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Witness (if client is unable to sign) Signature: _____

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