Dr. Pearl Zurich & Associates
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Release of and/or Request for Information

I, _____, authorize Dr. Pearl Zurich & Associates to release and/or

request information to/from: _____
(Name of Individual & Title or Organization)

_____
(Street Address)

_____
(City, State, Zip Code)

_____ _____
(Phone Number) (Email Address)

The purpose of this disclosure of information is to improve treatment planning, share information relevant to treatment, and when appropriate, coordinate treatment services (please check all that apply):

_____ Continuing Care Plan
_____ Diagnosis
_____ Participation in Treatment
_____ Psychological Evaluation
_____ Current Treatment Update
_____ Discharge/Transfer Summary
_____ Progress in Treatment
_____ Psychosocial Evaluation
_____ Demographic Information
_____ Medication Management
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____Psychotherapy Notes (cannot be combined with any other disclosure)

I understand that I have a right to revoke this authorization, in writing, at any time by providing written notification to Dr. Pearl Zurich & Associates. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

I understand that my refusal does not impact my ability to obtain services from Dr. Pearl Zurich & Associates.

I understand that unless sooner revoked, this authorization expires 180 days after date signed.

I understand that the disclosed protected health information pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by HIPAA privacy regulations. Unless specifically requested in writing that the disclosure be made in a certain format, Dr. Pearl Zurich & Associates reserves the right to disclose information as permitted by this authorization in any manner that they deem appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically. I understand that Dr. Pearl Zurich & Associates may charge a fee of $.65 per page up to 100 pages and $.35 per page thereafter for reproduction of records.

_____ _____
Signature of Patient or Personal Representative Date

_____
Printed Name of Patient or Personal Representative