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Zen for Change
Body, Mind, & Spirit Healing

REQUEST/AUTHORIZATON FOR RELEASE OF INFORMATION

I, _____, _____ hereby authorize Estefanía Simich, LCPC of Zen for Change, LLC to release information contained in my client records to the following individual(s) and/or organizations(s), and only under the conditions below:

1. Name of person(s), organizations(s), address to who disclosure is to be made:

_____ _____

2. Information to be disclosed:

☐ Treatment Summary

☐ Entire Record: _____

☐ Other _____

☐ Diagnosis ☐Attendance ☐ Progress ☐ Prognosis ☐ Drug/Alcohol History

☐ Mental Status Exam ☐ Discharge Summary

3. Purpose of disclosure:
☐ Provision of Mental Health Services ☐ Billing Purposes ☐ Aftercare Planning
☐ Continuity of Treatment ☐ Family Involvement ☐ P.O./Attorney/Judge/Court

4. Without expressed revocation, this consent expires 90 days after discharged from treatment.

_____
Client (Parent/Guardian) Signature/Date

_____
Clinician Signature/Date