Authorization for Use or Disclosure of Information

Alan Zupka, LMHC, NCC, MA. AZUPKACOUNSELING
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I, _____, hereby authorize Alan Zupka LMHC, NCC, MA to:

_____ release the following protected health information and/or
_____ receive protected health information from the following:

_____
Person/Organization

_____
Address City State Zip

_____
Phone Number Fax Number

The protected health information to be released about _____ will be information that originated in the office of Alan Zupka LMHC, NCC, MA only, not information that has been obtained from other sources. This information includes:

_____ Dates of service
_____ Type of service
_____ Psychosocial history
_____ Diagnosis
_____ Behavioral/Therapeutic observations
_____ Treatment plan
_____Other: _____

For the purpose of:
_____ Medical purposes
_____ Counseling purposes
_____ Educational purposes
_____ Coordination of care
_____ Other: _____

The authorization will be in effect until:
_____ 90 days after discharge
_____ Date of Discharge
_____ Other: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Alan Zupka LMHC, NCC, MA Orlando, FL 32803. I also understand, per the Notice of Privacy Practices, that the revocation might not be accepted if this protected health information has been relied upon for reimbursement or coordination of treatment.

_____ _____
Client: Print Name Signature Date