Nicolle Gottfried Zapien Psychotherapy

Authorization to Release Information

I, (Name of patient) _____(hereafter "Patient") hereby authorize Dr. Nicolle Gottfried Zapien (hereafter "Provider") to disclose mental health treatment information and/or records obtained in the course of psychotherapy treatment of the Patient, including but not limited to Provider's diagnosis and treatment of the Patient, to:

Name(s)

Telephone Number

I understand that I have a right to receive a copy of this authorization and that any cancellation of modification of this authorization must be received in writing by Provider at: 5625 College Avenue, Suite 216F, Oakland, CA 94618 to be effective. I understand, further, that I have the right to revoke this authorization at any time, in writing, unless Provider has already taken action in reliance upon it.

Provider shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form. Patient further understands that information disclosed, pursuant to this authorization may in some cases no longer be protected by the HIPAA privacy rule by the recipient named above, although California law may protect such information, regardless.

Name

Signature

This authorization shall remain valid until (date)