Marian R. Zimmerman, Ph.D.
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AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ Date: _____
Last First MI

Address: _____

City: _____ State: _____ Zip: _____

I, _____, hereby authorize Marian R. Zimmerman, Ph.D., P.A. to release and receive my psychological, personal, and medical information to/from the following individuals:

_____
Name

_____
Address

_____
Phone Number

I understand that disclosure of this information to the above individual will be made in order to assist my treatment.

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. If revocation is not received, authorization will be considered valid and shall not expire until 12 months from the date of signature.

_____ _____
Client Signature/Legal Representative Date

_____
Witness