

Authorization for Use, Disclosure, or Exchange of Health Information

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with the California and Federal law concerning the privacy of such information.

I hereby authorize the use, disclosure, or exchange of my health information as follows:

Name: _____

Use, Disclosure, or Exchange of Health Information - Initial only one of the following:

____ Use or disclosure only:

Person or Organization authorized to receive information _____

____ Exchange of Information:

Dr. Jill Zechowy is authorized to exchange information with _____

This authorization applies to the following information - Initial only one of the following:

____ All health information pertaining to any medical history, mental or physical condition and treatment received

____ Only the following record or types of health information (including any dates):

____ Psychotherapy notes (This requires a separate form be used to authorize release of any other health information.)

This authorization expires: _____

