Orange County Family Therapy
Individuals* Couples* Families* Adolescents* Marriage

Dr. Vennus Zand, Psy.D., LMFT #84766
(949) DIAL-MFT (949) 342-5638
8 Corporate Park, Suite 300 Irvine, CA 92602

General Release of Information

Client Name: _____ Date Of Birth:_____

I, the undersigned hereby authorize the ( ) Disclosure ( ) Exchange of the following Protected Health Information (PHI) between:

Name/Agency _____
Address _____
Phone number Fax
AND:

Name/Agency _____
Address _____
Phone number Fax

PURPOSE FOR RELEASE OF PHI:

( ) Aid by the Above-Named Agency
( ) Claims Settlement with Insurance Company
( ) Continued Care by the Receiving Facility/Doctor/Therapist
( ) Legal Proceeding
( ) Other _____

PHI TO BE RELEASED:

( )	Assessments	**( )**	Diagnosis Only	**( )**	Progress Reports
( )	Closing Summary	**( )**	Discharge Summary	**( )**	Psychiatric Evaluation
( )	Communications Only	**( )**	Lab Reports	**( )**	Psychological Tests
( )	Consultation Reports	**( )**	Medication Records	**( )**	Service Plan
( )	Coordination Plan	**( )**	Neurological Testing	**( )**	Other

This authorization is effective immediately and subject to revocation at any time, except to the extent that action has already been taken, and shall expire within 365 days from the date of signature.
I understand this authorization is required and I must voluntarily and knowingly sign this authorization prior to any records or information being released. In the event I refuse to sign the authorization, records and information cannot and will not be released.
I further release my therapist, Dr. Vennus Zand, from any liability arising from the release of information to the person(s)/agency designated above.
I have received a copy of this signed authorization. This authorization shall be terminated when withdrawn, and becomes void on my date of discharge.

_____ _____
Printed name of Client or Responsible Party **Relationship to Client**

_____ _____
Signature of Client or Responsible Party **Date**

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