TRACY R. ZEMANSKY, PH.D.
COURAGE TO CHANGE, INC.
Clinical Psychology: Psychological Assessment and Psychotherapy
Tel: 310-664-0454

Consent For Use And Disclosure Of Confidential Health Information

I, _____ authorize **TRACY R. ZEMANSKY, Ph.D**., to:

_____ Release requested information from my assessment and/or treatment records to the following person/persons or organization:
initial if ok

_____ Contact the following person/persons or organization to verbally discuss my case:
initial if ok

_____ Contact the following person/persons or organization to request disclosure of **verbal and written** confidential health information from them:
initial if ok

Name: _____

Address, Telephone Number, Email: _____

_____

Specific Information Requested: _____

_____

Information may be released/requested as needed until 90 days from treatment termination or until the following specified date: _____

_____

Client Signature/Date and Time:

_____

Parent (Other) Signature/Date and Time

_____

Therapist/Date and Time

Information disclosed is protected by Federal confidentiality rules (42 CFR part 2). The federal rules prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose.