Tzippy Kohen, MS, LCPC, NCC

323-896-2693

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I, _____, hereby authorize Tzippy Kohen, MS, LCPC, NCC to
___ disclose
___ obtain
mental health treatment information and records obtained in the course of my treatment, including, but not limited to, diagnosis of Client to:

_____

_____

_____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Tzippy Kohen has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Tzippy Kohen to be effective.

This disclosure of information and records authorized by Client is required for the following purpose: _____

Such disclosure shall be limited to the following types of specific information:

____ Progress Notes

____ Case Summary

____ Treatment Plan

____ Insurance Information, including diagnosis, dates of service, and procedure codes

____ Other information as specified below:

_____

Tzippy Kohen shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form.

Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient beyond the control of Tzippy Kohen and may no longer be protected by the HIPPA Privacy Rule.

This authorization shall remain valid for one year from date of form completion.

_____ _____
Signature of Client Date

_____ _____
Tzippy Kohen, MS, LCPC, NCC Date