Joel Ziff, Ed.D., Psychologist
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Authorization for Release of Information

Client Name:_____ Date of Birth: _____

Client Name #2:_____Date of Birth: _____

I hereby authorize Joel Ziff, Ed.D. to speak or correspond with the following clinician or person regarding my treatment:

Name of Practitioner(s): _____

Phone _____ Fax _____

Purpose of Disclosure: Coordination of Care (Psychotherapy)

I understand that once Joel Ziff discloses my health information to the recipient, Joel Ziff cannot guarantee that the recipient will not re-disclose my health information to a third party. Such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason, that such refusal or revocation will not affect the commencement, continuation or quality of my treatment with Joel Ziff; except, however, if my treatment with Joel Ziff is for the sole purpose of creating health information for disclosure to the recipient identified in this authorization in which case Joel Ziff may refuse to treat me if I do not sign this authorization.
I understand that this Authorization will remain in effect until the term of this Authorization expires or until I provide a written notice of revocation to Joel Ziff at the address listed below. The revocation will be effective immediately upon Joel Ziff's receipt of my written notice, except that the revocation will not have any effect on any action taken by Joel Ziff in reliance on this Authorization before he received my written notice of revocation. To contact Joel Ziff, please call 617-965.3932 or write to me at 610 Centre Street, Newton, Massachusetts 02458.
I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily authorize Joel Ziff to disclose my health information in the manner described above.

_____

Client Signature(s) **Date**

_____

Please Print Your Full Name(s)