Compass Psychological Services, LLC
Kara Zlotnick, Ph.D., NJ License 4416
216 Maple Avenue
Red Bank, New Jersey 07701
732.778.6360

Authorization for Release of Information

This form, when completed and signed, authorizes the release of protected information.

Name:_____ **DOB:**_____

I, _____ hereby grant my permission for the

☐ release or ☐ exchange of information

From: _____ **To**:_____

_____ _____

_____ _____

The purpose of the communication is to: ☐ Coordinate therapy with_____

☐ Other_____

This information may include: ☐ All relevant records and impressions

☐ Other_____

The following limits to this release apply: ☐ No limits

☐ Other_____

Release valid to the following date unless revoked in writing:

☐ Twelve (12) months from signature date ☐ Other date_____

I understand that I may refuse to authorize release of any information by withholding my signature.

Signature_____**Date**_____

Relationship: ☐ Self ☐ Parent ☐ Guardian

For patients 14 years and older:

Signature_____**Date**_____

Notes: 1. You may cancel this authorization by submitting a letter to your therapist in person or by mail. 2. We cannot protect your confidentiality of information or records once sent to others and these items may no longer be protected by the HIPAA Privacy Rule. 3. In most cases, you are not required to sign this form in order to receive psychological services.