P.O. Box 521
Ashland, OR 97520

Kim Zwemer-Margulis, M.S.
Licensed Professional Counselor

Email: kimzmarg@gmail.com
Phone: 541-821-0417
fax: 541-201-8603

Consent to Release Confidential Information to Another (Third) Party

1. I, _____ (print your name and date of birth), am completing this form to allow the use and sharing of my protected health information.

2. I authorize Kim Zwemer-Margulis, M.S. to disclose my counseling treatment records (which may include a biopsychosocial assessment and/ or progress notes).

3. Dates of care for which the information will be disclosed include: From ***beginning of this treatment episode*** to ***present time*** Or specify the time period for which you are giving Kim Zwemer-Margulis the permission to release your records:

From _____ to _____ and

4. I authorize to disclose the above noted information to this person &/or organization:

   (list below the person(s) and/or the organization(s) that will be receiving your records from Kim Zwemer-Margulis; please, be sure to provide complete address and contact information for this "third" party)

   _____

   _____

   Street: _____ City: _____ Zip Code: _____

   Phone: _____ Fax (if known): _____

5. The information will be used/disclosed for the following purposes (e.g. continuity of care):

   _____

   _____

6. I understand and agree that this Authorization will be valid for one year from this date unless specified otherwise here:

   _____

[Note a date or event upon which this Authorization expires. For example, you may choose to have this authorization expire 1 month from today or 6 months from today; or you may request that this authorization expire upon such event as the termination of therapy with Kim Zwemer-Margulis,

in which case write down in the space above “termination of therapy with Kim Zwemer-Margulis”.

I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.

7. I understand that I can revoke or cancel this authorization at any time by sending a letter to Kim Zwemer-Margulis. If I do this, it will prevent any disclosures after the date it is received but can not change the fact that some information may have been sent or shared before that date.

8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed at number 2, above, nor will it affect my eligibility for benefits.

9. I understand that I may inspect and have a copy of the health information described in this authorization. There may be a cost for this copy or other services.

10. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

12. I affirm that everything in this form that was not clear to me has been explained and I believe now understand all of it.

_____ _____

13. Signature of client or his or her personal representative Date

14. I (the client) acknowledge that I received a copy of this completed form: _____ (please, initial here)I (the client) have declined the copy of this completed form: _____ (please, initial here)

15. I, Kim Zwemer-Margulis M.S., have discussed the issues above with the client and/or his/her personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____ _____

Signature of professional Printed name of professional Date