Dr. Laura A. Zipris, PA

5300 West Atlantic Avenue
Suite 408
Delray Beach, FL 33484
561-558-7815

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

By signing this form you are authorizing Dr. Laura Zipris, PA to release otherwise confidential information to one or more people whom you designate. Please read carefully. I will gladly answer any questions.

I authorize Dr. Laura A. Zipris to: (Check all that pertain)

- ☐ Discuss otherwise confidential information pertaining to my treatment
- ☐ Transmit a copy of my otherwise confidential health record
- ☐ Transmit a letter or treatment summary containing my otherwise confidential information

I authorize the release of the information specified above to:

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If you have authorized Dr. Laura Zipris to discuss confidential information, specify the period during which she may communicate with the person(s) listed above, by checking the appropriate box below:

- ☐ I authorize ongoing communication unless I revoke the consent.
- ☐ I authorize communication only until _________________________(specify the date)

Other restrictions or limitation on information to be released (specify):

____

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- ☐ No other limitations

I understand that I do not have to agree to release confidential information, and that I may withdraw consent at any time except insofar as action has already been taken in reliance thereupon. A facsimile of this form with be regarded as valid as the original.

Signature:____

Name (printed):_______________________________________

Date: ____