Authorization for Release of Information

Philip Zimmerman, LMFT
Counseling and Spirituality

I, _____ (Social Security # _____

Date of Birth _____) agree that my Therapist, Philip Zimmerman, may contact or

be contacted by the following on my behalf to discuss my case and my needs:

Agency	**Contact Name**	**Phone Number**

I understand that by signing this release of information, my Therapist will be contacting or will be contacted by the person(s) or agency (ies) listed above and that the information I have provided to my Therapist, may be shared for my benefit.

I understand that this form is valid as long as I am considered an active client with my Therapist.

Client Name (printed): _____

Guardian Name (if client is under 18) (printed): _____

Client Name (or Guardian) (signature): _____

Specific Information Requested: _____

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