In accordance with HIPAA privacy laws, a signed consent form is required to release information in any form about your care. This authorization allows us to communicate when needed or requested regarding scheduling, insurance or billing information, as well as routine or emergency contact. This authorization may be rescinded or amended at any time that you choose.

Please use the space below to identify any persons with whom you may want us to have contact.

I, _____, certify that I am 18 years old or older and give permission for ZOE Therapy Services to communicate with the following persons about my treatment:

Name	Relationship	Phone
1)_____		
2)_____		
3)_____		
4)_____		

_____ ***No Authorization to Release Information to any Nonprofessionals***

Please Check

Print Patient's Name_____

Signature of Patient_____ Date_____