ZEN AGAIN
THERAPY AND WELLNESS

Medical Records Release Authorization

Patient Information:

Name: [Your Name]
Date of Birth: [Your Date of Birth]
Address: [Your Address]
Phone: [Your Phone Number]
Email: [Your Email Address]

Recipient Information:

Dr. Lindsey R. Goldberg, Psychiatric Mental Health Nurse Practitioner
Zen Again Therapy and Wellness
Phone: 919-630-5550
Fax: (949) 695-4634
Email: medicalrecords@zdoc.life

Authorization:

I, [Your Name], hereby authorize the release of my medical records and health information to Dr. Lindsey R. Goldberg, Psychiatric Mental Health Nurse Practitioner at Zen Again Therapy and Wellness, PLLC. This authorization includes, but is not limited to, all medical records, mental health records, and any other pertinent information necessary for my continued care and treatment. Including phone and email conversations.

Purpose of Disclosure:

The purpose of this disclosure is to allow Dr. Lindsey R. Goldberg, Psychiatric Mental Health Nurse Practitioner at Zen Again Therapy and Wellness, to review my medical history and provide appropriate psychiatric and mental health care.

Duration of Authorization:

This authorization is valid until [Specify Date or Event], unless revoked in writing by me prior to this date.

Signature:

I understand that I have the right to revoke this authorization at any time by providing a written notice to the health care provider. I acknowledge that a revocation will not affect any disclosures made prior to the receipt of the revocation.

Signature: _____
Date: _____
Printed Name: _____