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Authorization for Use or Disclosure of Protected Health Information

We value your right to confidentiality. However, to better serve you, we ask that you give us permission to contact the following person or institution to obtain further information. The information we receive shall be subject to the same privacy rights detailed in our Notice of Privacy Practices and will not be disclosed without your prior written consent or as required or permitted by law.

CLIENT INFORMATION:		
Name of Client:	Birthdate:	
Other Names Used (e.g., maiden name):		
Street Address:	City/State:	Zip Code:

AUTHORIZES THE FOLLOWING ENTITY TO RELEASE INFORMATION:		
Name of Person/Institution:		
Street Address:	City State:	Zip Code:
Tel. No:	Tel. No:	E-mail:

TO (receiving information):		
Name of Person/Institution: Jo Anne Kaplan, MFT, Ph.D./Franco E. Santos, M.A., MFTI		
Street Address: 18401 Ventura Blvd., Suite 118	City State: Tarzana, CA	Zip Code: 91356
Tel. No: 818-748-5654	Tel. No:	E-mail: franco@francosantos.com

REQUESTED INFORMATION:			
<input type="checkbox"/>	Assessment and Evaluation	<input type="checkbox"/>	Results of Psychological Tests
<input type="checkbox"/>	Laboratory Results	<input type="checkbox"/>	Medication History/Current Medications
<input type="checkbox"/>	Entire record	<input type="checkbox"/>	Diagnosis
<input type="checkbox"/>	Treatment	<input type="checkbox"/>	Other: _____ _____

PURPOSE OF REQUEST FOR INFORMATION:

