Dr. Jessica Katzman

3150 Mission Street, Suite 550, SF, CA 94110
Phone: (415) 570-4277 Fax: (415) 520-9128

AUTHORIZATION TO RELEASE INFORMATION

Client's Name:

Date of Birth:

Social Security #:

I request and authorize **Dr. Jessica Katzman, Licensed Clinical Psychologist** to release healthcare information of the client named above to:

Name/Phone: _____

Address:_____

This request and authorization applies to:

☐ Participation/attendance in psychotherapy only

☐ Mental health and substance abuse treatment (including assessment, diagnoses, treatment, medication, discharge summary)

☐ Other: _____

AUTHORIZATION: I understand that signing this authorization is voluntary, and by signing this authorization I am amending my rights to confidentiality. I have a right to obtain a copy of this authorization. I understand that I may revoke this authorization at any time by submitting a request in writing. I understand any request for revocation will not have any effect on any actions taken prior to its submission. I understand that if the entity authorized to receive the information is not a health plan or healthcare provider, the released information may not be protected by federal privacy regulations. This authorization will not expire unless otherwise stated. I understand that this request may result in an administrative copying fee.

_____ _____

(Client Signature) (Date)