 **Integrative Psychotherapy**

**Kymberly Haas**

**LMFT, CADC-II**

1710 Hamilton Ave STE 8

San Jose, CA 95123

Phone: 916.370.5381 Fax: 916.367-0535

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient’s Name: | | | | | | |  | | | Date of Birth: | | |  | | | | | |
| Previous Name: | | | | | | |  | | | Social Security #: | | | |  | | | | |
| I request and authorize | | | | | | | | |  | | | | | | | | | to |
| release healthcare information of the patient named above to: | | | | | | | | | | | | | | | | | | |
|  | | Name: | | | |  | | | | | | | | | | | | |
|  | | Address: | | | | | |  | | | | | | | | | | |
|  | | City: | | |  | | | | | | State: |  | | | Zip Code: | |  | |
| This request and authorization applies to:  🞎 insurance Billing | | | | | | | | | | | | | | | | | | |
| 🞎 Healthcare information relating to the following treatment, condition, or dates: | | | | | | | | | | | | | | | |  | | |
|  |  | | | | | | | | | | | | | | | | | |
| 🞎 All healthcare information | | | | | | | | | | | | | | | | | | |
| 🞎 other: | | |  | | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | | | | | | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | 🞎 Yes 🞎 No | I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above. | | | | | Client Signature: | |  | Date Signed: |  | |  | | | | | | THIS AUTHORIZATION EXPIRES on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. | | | | | | | | | | | | | | | | | | | | | | | |
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