CONSENT TO RELEASE INFORMATION

Eugene Kranz, Ph.D. Lic #: 23155
T: 805-748-3055
F: 877-645-6250

Please initial and sign the statements below giving your permission for me

Initial : ____ **to communicate (check)** ___ **email** ___ **fax** ___ **phone** ___ **in person**

Initial: ____ **release mental health records** _____ **substance use history** ____ **financial information**

with the following individual or agency on your behalf:

____

(Name of individual or agency you are allowing me to contact)

____

(Address of individual or agency if applicable)

____

(Phone, email, or fax of individual/agency.

Purpose of release (check): ___ coordination of care ___ Legal ___ personal ___ financial

I, ___________________________, hereby authorize __________Eugene Kranz, Ph.D.__________

(Your name) (Name of doctor)

to disclose or obtain information regarding my treatment (or the treatment of a minor).

This has been discussed and I agree that Dr. Kranz may contact and release the above mentioned information to the above mentioned individual(s) for the purposes we have agreed upon. I have the right to revoke this consent at any time except to the extent the consent has already been acted upon. This authorization expires in 1 year from today's date, or this earlier date:______________ or when the following event occurs: ________________________.
I understand that I have a right to receive a copy of this authorization upon my request.

_______________________________________ _____________________

Name of Patient (or parent/guardian) Date

____

Signature of Patient (or parent/guardian)

____

(if this consent is on behalf of a minor, please print the minor's name here)

_______________________________________ _____________________

Signature of minor if appropriate Date