KATZ PSYCHOLOGICAL SERVICES, PLLC

Authorization for REQUEST Protected Health Information FROM/TO Person/Organization

I, CLIENT INFO _____ _____ _____
Patient's Name SSN Date of Birth

Address: _____ Phone: _____

City: State: Zip:

Request

Agency/Provider Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Fax:

To release the information described below to:

Dr. Jamie N. Katz, Psy.D.

Address: _____

City: _____ State: _____ Zip: _____

Phone: 480-766-3470 Fax:

Information requested. Check all that apply:

☐ Clinical Assessment	☐ Psychiatric Evaluation	☐ Medications
☐ Clinical Services Notes	☐ Treatment/Service Plans	☐ Test Results/Labs
☐ Discharge Summary	☐ Substance Abuse Information	☐ AIDS/HIV Information
☐ Other (Specify)		

Purpose for Request/Disclosure: COORDINATION OF SERVICES

Authorization will expire: ☒ One Year From this Date:_____

_____ _____
Signature of Patient/Guardian Date of Patient/Guardian Signature

_____ _____
Other Required Signature (if applicable) Witness (if patient is unable to sign)