West Hollywood Counseling
Joey Sarcoz, MA, LMFT
8235 Santa Monica Blvd. Suite 400
West Hollywood, CA 90046
424-335-0144

Release of Confidential Health Care Information

I herby authorize Joey Sarcoz, MA, LMFT to disclose clinical records and/or information concerning_____, date of birth_____, obtained during the course of his/her treatment to_____.

The disclosure of information authorized herein is required for the following purpose(s):
_____

_____

_____

These records are protected by the California Welfare and Institution Code Section 5328 and HIPPA laws. An additional consent must be obtained for any other transfer or disclosure of information.

The authorization shall be effective_____, and is effective to revocation by the undersigned at any time, except to the extent that the action has already been taken. If not earlier revoked this consent shall terminate on_____, not to exceed one year. I sign this document with the full knowledge of its purpose and without duress.

_____

Patient Signature

_____

Joey Sarcoz, MA, LMFT