Judy Kann
PsyD, LCSW

Release of Information

Name _____ **Date** _____

I authorize the exchange of information/records between Judy Kann, PsyD., LCSW and

_____

The following information/records may be exchanged:

- ☐ Phone Consultation
- ☐ Dates of Treatment
- ☐ Treatment Summary
- ☐ Diagnostic Information
- ☐ Release of Medical Records
- ☐ Release of Psychiatric/Psychological Records
- ☐ Results of Educational/Psychological Testing
- ☐ Other _____

I recognize that this Release of Information is effective until 3 years from the date that it is signed. I also recognize that it is my right to revoke this Release of Information at anytime.

_____
Printed Name

_____ _____
Signature Date

_____ _____
Signature of Responsible Party (if other than person) Date

_____ _____
Witness Date

Psychoanalyst/Licensed Clinical Social Worker (LCS 11336), TIN 311805305
1849 Sawtelle Blvd. #540 Los Angeles, CA 90025 310.479.1026
westsidetherapy.com | jkann@chillco.com