Jeff Strnad
Licensed Marriage and Family Therapist #88870
JS Marriage and Family Therapy PC
91 Peter Coutts Circle
Stanford, CA 94305
(650)-427-0197

AUTHORIZATION FOR RELEASE OF INFORMATION

I _____authorize Jeff Strnad to release information to and receive information from:

_____
(Name of Individual and Organization)

Address: _____

Phone Number: _____

Email: _____

Reason for release: Coordination of Care____ Emergency Only____

Limits of release: _____
(state "none" if none)

This release expires when the therapeutic relationship is terminated or one year from the date below, whichever is earlier, but it is revocable by Patient at any time through a written request for revocation.

Patient Information

Name: _____

Address: _____

Date of Birth: _____ Phone Number:_____

The authorization for disclosure of information is made with informed consent. A scanned copy this release shall be considered as effective and valid as the original document.

Patient Signature: _____

Date: _____