

Joanne Kaplan, MFT, PhD
• P.O. Box 16731 • Encino, CA 91416 • 818-609-0607 •

PATIENT CONSENT FORM

Patient Name: _____ Date: _____

Authorization to Release My Medical Records

I, _____ authorize that _____ release medical records of my evaluations and treatment to Joanne Kaplan, MFT, PhD.

Signed and Agreed: _____ Date: _____

Authorization to Receive My Medical Records

I, _____, authorize that Joanne Kaplan, MFT, PhD release medical records of my evaluations and treatment. I wish these records to be sent to:

Signed and Agreed: _____ Date: _____

Authorization to Bill for Payment

I, _____, authorize that Joanne Kaplan, MFT, PhD bill my insurance company for medical services rendered to me. I also authorize my insurance carrier to make payment to Joanne Kaplan, MFT, PhD for services rendered to me for evaluation and treatment of my condition related to the medical or psychiatric diagnoses appearing on my insurance claim form and/or statement/bill. I authorize Joanne Kaplan, MFT, PhD to furnish my insurance company with medical and other information about me (e.g., evaluation reports, treatment notes) that is required for processing my claim for medical benefits to be paid. I realize that I am financially responsible for all insurance deductibles and co-payments, as well as for services to which I consent that are not covered by insurance.

Signed and Agreed: _____ Date: _____

Informed Consent for Evaluation and Treatment

I, _____, agree that this authorization shall also serve as my informed consent to medical evaluation and treatment.

Signed and Agreed: _____ Date: _____

Authorization to Use Copies of This Document and Term of This Authorization

I, _____, also permit a copy of this entire authorization to be used in place of the original. This entire authorization will remain in effect until revoked by me in writing.

Signed and Agreed: _____ Date: _____

Witness: _____ Date: _____