David B. Franklin, Ph.D., LCSW
19206 Huebner Road; Suite 104
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CONSENT TO OBTAIN AND RELEASE CONFIDENTIAL INFORMATION

Client Name: _____
Address:_____
City:_____ State:_____ Zip:_____
Phone #:_____ Date of Birth:_____SS#:_____

Authorizes David B. Franklin, PhD to
☐ to send ☐ to receive information to ☐ from ☐ :

Name_____

Address_____

Phone_____

Information to be released:

☐ Initial Evaluation ☐ Treatment Summary ☐ Court Ordered Social Study

☐ Progress Reports ☐ Verbal Communication ☐ Continuity of Care Information

Other (please specify)_____

This authorization, or a copy of this authorization, is for valid for l year from the date signed.

I have read and understand all of the above information

_____ _____
Signature of patient or legal guardian (if applicable, relationship of legal guardian to patient) Date

_____ _____
Signature of patient or legal guardian (if applicable, relationship of legal guardian to patient) Date

_____ _____
David B. Franklin, PhD, LCSW Date