Oceanside Family Therapy

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize Nicole Story, EdS, MEd, LMFT, LMHC/Oceanside Family Therapy to

release and/or exchange healthcare information of the patient named above to/with:

Name: ____

Address: ____

City: ______________________ State: __________ Zip Code: __________

This request and authorization applies to:

☒ Healthcare information relating to the following:

Mental Health Diagnosis/Presenting Issues/Assessment/Treatment Planning/Progress/Discharge Planning

☐ All healthcare information/Entire record

☐ Other: ____

Patient Signature: ______________________ **Date Signed:** ______________

For minors:

☐ Yes ☐ No I authorize the release of my minor child's mental health/counseling information, to the person(s) listed above.

Parent/Guardian Signature: ______________________ Date Signed: ______________

Parent/Guardian Name: ______________________ Relationship: ______________

THIS AUTHORIZATION EXPIRES ONE HUNDRED AND EIGHTY DAYS AFTER IT IS SIGNED.