**Oceanside Family Therapy**

Nicole Story, EdS, MEd, LMFT, LMHC
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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 YEAR AFTER IT IS SIGNED.