NURTURING SOLUTIONS
A FAMILY THERAPY & CONSULTATION PRACTICE

Release of Information

Please sign the statement below giving your permission for me to communicate with the following individual, agency, or insurance company on your behalf:

_____
(Name of individual, agency, company to be contacted)

_____
(Address, city, state, zip of said individual, agency, company)

_____
(Phone/fax)

I, _____, born on _____, hereby authorize
(Name of patient/guardian) (Birthdate)

Marla Flores, M.F.T to disclose/obtain (circle one or both) the following information from clinical records:

☐ Diagnosis and dates of treatment ☐ Summary of treatment

☐ Psychological evaluation/assessment ☐ Relevant treatment records

☐ Other: Phone conversations

regarding myself/my child, _____
(Child's full name)

for the following purpose: Coordination of Care.

This authorization and request to disclose or obtain information from my records will expire after one (1) year from the date on which it was signed. I agree that a photocopy of this release form is acceptable. I understand that I have the right to receive a copy of this authorization upon my request.

Patient Name/Guardian Name_____

Patient/Guardian Signature _____Date_____

Relationship to patient: ☐Self ☐Parent of a minor

***Please note that all parties who have been present in the office, over the age of 11, must sign the release.*