Plumeria Counseling Center
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www.plumeriacounseling.com

Authorization for Release of Information

Name: ______________________________ Date of Birth: ______________________

Address: ______________________________ City, State, Zip: ______________________

☐ I authorize Plumeria Counseling Center to release information to:

AND/OR

☐ I authorize Plumeria Counseling Center to obtain information from:

Release information to	Obtain information from
Name of Provider or Facility	Name of Provider or Facility
Address	Address
City, State, Zip Code	City, State, Zip Code
Phone #/Fax # (Include area code)	Phone #/Fax # (Include area code)

PURPOSE OF THIS REQUEST: (check one) ☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Other

TYPE OF RECORDS AUTHORIZED: ☐ Psychiatric/Psychological Evaluation and/orTreatment
☐ Drug/Alcohol Evaluation and/orTreatment

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

☐ Assessments ☐ Progress Notes ☐ Test Results: ______________ ☐ Diagnostic Impression
☐ Discharge Summary ☐ Treatment Plans ☐ Treatment Summary
☐ Other: (please describe) ______________________________

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. **My authorization will expire:**

☐ When the requested information has been sent/received. ☐ 90 days from this date. ☐ Other: ______________

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.
My authorization will expire:

☐ When I am no longer receiving services from Plumeria Counseling Center. ☐ One year from this date. ☐ Other: _______

Signature of Client: ______________________________ Date: ______________________