Angela P. Wu, LCSW
TherapistAndCoach.com
(949) 933-9146

Release of Information Form

Client Name: _____
(first) (middle) (last)

Address: _____
(street) (city) (state) (zip code)

Phone: _____

I AUTHORIZE:

Angela P. Wu, LCSW - www.TherapistAndCoach.com
(949) 933-9146

TO: ☐ **EXCHANGE** ☐ **DISCLOSE/RELEASE ONLY** ☐ **RECEIVE ONLY**

TO/FROM: _____
(Name of Person/Organization)

_____
(address)

_____
(phone and fax)

THE FOLLOWING INFORMATION:

☐ Psychotherapy notes from _____ to _____ (dates) ☐ Medical records
(i.e.: assessment, diagnosis, care plan, progress notes, discharge summary)

☐ List of medications ☐ Other/Specific records _____

_____

FOR THE PURPOSE OF:

☐ Continuity of care ☐ At the request of the patient ☐ Care planning/coordination
☐ Other: _____

THIS AUTHORIZATION IS VALID:

☐ One time only ☐ for 6 months from the date below ☐ for 1 year from the date below
☐ Until _____

_____ _____ _____
Client Signature Date Provider Signature

_____ _____ _____
Parent/Legal Guardian Name (please print) Date Parent/Legal Guardian Signature