

**Marla Flores, M.F.T.**  
741 Garden View Court, Suite 210  
Encinitas, CA 92024  
(760) 271-3165

## **Release of Information**

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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:

- |  |   |
|--|---|
| <input type="checkbox"/> Diagnosis and dates of treatment    | <input type="checkbox"/> Summary of treatment       |
| <input type="checkbox"/> Psychological evaluation/assessment | <input type="checkbox"/> Relevant treatment records |
| <input type="checkbox"/> 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.