Dr. Lacy Olson-Ayala

www.DrOlsonAyala.com ● info@drolsonayala.com ● Phone: 424.653.6175

Release of Information Form

I, _____, the undersigned, give permission to Dr. Lacy Olson-Ayala, Licensed Clinical Psychologist, to release and provide information to:

_____ (Name)

_____ (Address)

_____ (Phone Number)

the following information (check all that apply)

☐ my attendance in therapy

☐ my diagnosis

☐ my treatment plan

☐ information relevant to coordinating care

☐ when treatment is terminated and why

☐ other (please explain in detail)

_____

I understand that that this release is valid for ☐ a period of 120 days or ☐ until the need for such disclosure no longer exists. I further understand that I may revoke this authorization at any time in writing.

In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

_____ _____

Signature Date