Authorization for Release of Information

Patient Name   Date of Birth

Address   City   State   Zip

Phone   Fax

An authorization to disclose information is voluntary.

I authorize Ginger Houseman, MFT to: Exchange, Share, and/or Obtain Information with:

Name/Agency

Address   City   State   Zip

Phone   Fax

☐ All information related to the coordination of care and treatment planning
☐ Other (Please Specify)

This authorization is limited to: ☐ Completion of this request ☐ Six months from date below or ☐ End of treatment. You may revoke this authorization at any time by sending a written notification to Ginger Houseman, MFT at the address below suspending this authorization.

Signature   Date

Relationship to patient

Ginger Houseman, MS, MA, MFT
4425 Jamboree Road, Suite 270, Newport Beach, CA 92660
Phone: (949) 584-2581