LAURA ESPINOSA, PLLC

LAURA M. ESPINOSA, PSYD, LP
LICENSED CLINICAL PSYCHOLOGIST

Release of Information and Coordination of Care

I, _____ give my permission to Dr. Laura Espinosa to exchange written or verbal communication regarding my treatment (including, but not limited to diagnosis, prognosis, treatment plan, medication information, goals, billing information, recommendations, and progress notes) with _____

_____

_____

for the purpose of facilitating my mental health care treatment and coordination of care, or for release to court or administrative agency.

This authorization may be revoked in writing at any time prior to release.

Patient Signature _____ Date _____

Therapist Signature _____ Date _____