The Women's Corner
Allison Nurse-Hofer, LMFT, MA, MBA
2730 Wilshire Blvd ste 650
Santa Monica, CA 310.205.2655

Consent for Release of Information

I, _____, authorize the mutual sharing and release of information regarding my medical and mental health care and other types of services being provided between my therapist, Allison Nurse-Hofer, LMFT, and the contact(s) listed below. I understand that this exchange of information may include past treatments and evaluations, as well as current functioning and concerns. This exchange of information is for the purpose of treatment planning and evaluation, and the comprehensive coordination of my care. I understand that this authorization expires one year from the date it was signed, unless revoked in writing prior to its expiration date.

Contact(s) with whom information will be exchanged (Primary Care Physician, Psychiatrist, Specialty Provider, Clinic, Organization, Family Member etc…)

1) Name:_____

Title:_____

Phone:_____

2) Name:_____

Title:_____

Phone:_____

3) Name:_____

Title:_____

Phone:_____

_____ _____

Signature of authorizing party Date