Monica Rodriguez Counseling LLC
Oconomowoc, WI 53066

AUTHORIZATION TO RELEASE INFORMATION

Client Name:_____ DOB:_____

Legal Guardian Name:_____

I authorize: Monica Rodriguez
Monica Rodriguez Counseling, LLC
405 East Forest Street, Suite 119
Oconomowoc, WI 53066

Phone: 262-490-3894
Fax: 262-567-5323

To: _____Release and Obtain _____Obtain _____Release

To/From: _____
Name

_____
Address

_____ _____
Phone Number Fax Number

The following specific information or reports from my records:

_____ Assessment
_____ Diagnosis
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management
_____ Presence/Participation in Treatment

_____Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Other_____

_____
Signature of Client/Parent/Legal Guardian Date

_____
Signature of Witness Date