Lucas Plumb, PhD, PSY 24405

1008 Fifth Street
Santa Rosa, CA 95404
(707)529-3030
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Consent to Release Protected Health Information

Today's Date_____

Name_____ Age _____DOB_____Gender: M F T Fluid

Address _____ Social Security # _____

City / State / Zip _____ Cell Phone (_____)_____

Other phone or fax (_____)_____ Email Address _____

I the undersigned, hereby voluntarily authorize the exchange of information between the following providers and/or the authorized representatives of the following agencies/organizations as indicated. I understand that if the organizations/agency authorized to receive the information is not a health care provider, Federal Privacy Regulations may no longer protect the released information.

FROM	TO
Lucas Plumb, Psychologist 1008 Fifth Street Santa Rosa, CA 95404 (707)529-3030 drlucasplumb@gmail.com	_____ _____ _____ _____ _____

Circle the type of information requested:

Diagnosis	Summary of Notes	Session Start/Stop Times
Prognosis	Treatment Plan	Symptoms
Modalities	Progress to Date	Clinical Test Results
Frequency	Dates of Treatment	Other _____

This exchange of information is for the purpose of providing effective evaluation, treatment and appropriate services. I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoke, this authorization will expire on the following date, at the end of treatment or under the following conditions:

LIMITATIONS ON THIS RELEASE _____

_____

_____

I further understand that the information provided to Dr. Lucas Plumb will be kept CONFIDENTIAL and is protected by Federal Privacy Regulations. I also understand that Dr. Plumb is not responsible for any mishandling of my information by other agencies or organizations to whom I authorize the release.

SIGNED_____ DATE_____ WITNESS_____