Paul Gillane LMFT

Consent to Release Information

CASE NAME ________________________________

DATE OF BIRTH ______________________________

COUNSELOR ________________________________

This release of information form authorizes information from my records (or my child's records) to be shared between the counselor listed above and the person(s) or agency listed at the bottom of this form.

I give permission to the counselor listed above and the person(s) or agency listed below to share and exchange the following information:

_____ Educational   _____ Psychiatric

_____ Medical   _____ Social

_____ Psychological   _____ Psychometric Testing

I understand that this authorization is valid for two years from the date listed below. I also understand that this information may not be released to any other person or organization without my permission in writing. A photocopy of this authorization shall be considered valid.

____
Person(s) / Agency

____
Signature of Client

____
Street Address

____
City   Zip

____
Signature of Parent/Guardian

____
Date

____
Printed Name of Parent/Guardian

____
Witness/Title (Counselor)