Gilbert Counselors, LLC

Professional Counseling Services

1425 W. Elliot Rd, Suite 201 * Gilbert, AZ 85233 *
gilbertcounselors.com

Authorization for Release and Exchange of Information

I, ______________________________, ____________________, ________________________
client name date of birth social security number

authorize Gilbert Counselors, LLC, to exchange the information checked below with the below mentioned party:

____
(Name of party) (Phone #) (Fax #)

_____ Mental Health Info. _____Substance Abuse Info. _____Medical Info.

_____ Other (describe) ____

_____ If checked, both parities may exchange information.

This authorization may be withdrawn at any time in writing except to the extent that the program or person which is to make this disclosure has acted in reliance on it. Upon revocation of this authorization, further release of information shall cease immediately. This consent will expire automatically upon completion / termination of treatment. Any disclosure of medical record information by the recipient(s) is not authorized except when implicit in the purposes of the disclosure.

____ ____________________
Client Signature Date

____
Signature of Parent, Guardian, or authorized representative Date