**Gilbert Counselors, LLC**

**Professional Counseling Services**

1425 W. Elliot Rd, Suite 201 \* Gilbert, AZ 85233 \* 480-223-0223

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 parties 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This authorization may be withdrawn at any time in writing except to the extent that the program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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date