



Cindy Gullo, LCPC
— MENTAL HEALTH THERAPIST —

Authorization for Release of Information

Client's Name: _____ DOB: _____

I authorize and request Cindy Gullo, LCPC to release/exchange confidential information contained in my child's clinical record.

Persons (s) Authorized to Release Information: _____

Persons (s) Authorized to Receive Information: _____

The following REQUESTED items to be disclosed:

- | | | |
|--|---|---|
| <input type="checkbox"/> Any/All Information | <input type="checkbox"/> Summary of Care/Services | <input type="checkbox"/> Dates of Service |
| <input type="checkbox"/> Psychotherapy Notes | <input type="checkbox"/> Written Communication | <input type="checkbox"/> Verbal Communication |

The PURPOSE for this disclosure:

- | | | |
|--|---|------------------------------------|
| <input type="checkbox"/> Client Care/Treatment | <input type="checkbox"/> Attorney/Court Ordered | <input type="checkbox"/> Insurance |
|--|---|------------------------------------|

This authorization will expire on ____/____/____ or at any time prior to this date, when I have provided written documentation to cancel this authorization.

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that information disclosed is protected by law, and the use/disclosure is made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use/or re-disclosure of my confidential health information.

Parent/Guardian's Signature: _____ Date: _____