Cindy Gullo, LCPC
MENTAL HEALTH THERAPIST

Authorization for Release of Information

Client's Name:_____DOB:_____

Parent Name:_____Today's Date:_____

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:

- ☐ Any/All Information
- ☐ Summary of Care/Services
- ☐ Dates of Service
- ☐ Psychotherapy Notes
- ☐ Written Communication
- ☐ Verbal Communication

The PURPOSE for this disclosure:

- ☐ Client Care/Treatment
- ☐ Attorney/Court Ordered
- ☐ 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 child's confidential protected health information, as described in my directions above. I understand that this authorization us 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 this authorization may be re-disclosed by the recipient unless the recipient us covered by state laws that limit the use/or re-disclosure of my confidential health information.

Minor Client's Signature (12-17 years old):_____Date:_____

Parent/Guardian's Signature:_____Date:_____