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AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

Client Name:_____ Date:_____

Address:_____City:_____Zip:_____

I, _____ give Gail D. Gerbie, LMFT authorization to:

_____Provide my client records to _____
Name Contact Information

_____
Phone Email Address

Purpose:_____

_____Discuss my case with_____

_____

Purpose:_____

This release will remain in effect for one year after the date of signature.

Signature:_____Date:_____

If a minor, Parent's Signature:_____Date:_____