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Dr. Gina Galloway, P.L.L.C.
Licensed Professional Counselor

Authorization and Consent for Release of Information

Pursuant to Federal Guidelines concerning my right to confidentiality and state law concerning privileged communications, I hereby authorize Gina Galloway to communicate with:

Name_____

Address_____

Phone number_____

in the following manner:

____to mutually disclose records/information, both written and verbal
____to request information
____to release information

concerning:

Name_____

Address_____

Phone number_____

The information to be used will be limited to the following (check any that apply):

_____medical records (dates: _____) _____services, records, reports
_____evaluation reports _____psychological testing results
_____case notes
_____other (specify):_____

This authorization shall expire when:

_____
(date/condition, not to exceed 6 months)

I understand that if I am signing as the parent of a minor or as a guardian, the records release may contain references to myself and my family. I understand that I may revoke this consent to release information at any time prior to the stated expiration above. I also understand that any release made between the time I authorized it and then revoked it shall not constitute a breach of my right to confidentiality.

_____ _____
Client signature Date

_____ _____
Parent/Guardian signature (if applicable) Date

Please send any requested records to the attention of Dr. Gina Galloway.