Gesell

Authorization to Obtain or Release Confidential Information

I, _____ , authorize Gesell Psychotherapy, LLC to release / obtain information that is pertinent to my therapy or evaluation with any person/s or staff of clinic, office, agency or institution/s named below.

_____

(Contact Information)

_____

(Contact Information)

_____

(Contact Information)

Reason(s) for the release of information:

_____ Consultation

_____ Course of Psychotherapy/Diagnosis

_____ Evaluation

_____ Other: _____

_____

This consent is in effect for one year from the date of signing, unless revoked in writing or until the termination of therapy. I understand that I may revoke this consent at any time. I understand that any cancellation or modification of this authorization must be in writing.

_____

(Patients Name) Please Print out Name

_____ _____

(Patient's Signature) **(Date)**