GRAY
Consulting & Therapy, LLC

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

I, _____ (hereinafter "Client") hereby authorize Gray Consulting and Therapy, LLC, "Provider") to disclose/evaluation and therapy information and records obtained in the course of my services with Gray Consulting and Therapy, LLC, to:

Name/Organization:	
Address:	
Email:	
Phone:	Fax:

For the purposes of (check all that apply):

- ❑ Coordinating services among other professionals
- ❑ Updating progress toward goals
- ❑ Providing continuity of services
- ❑ Other:

Shared information may include:

- ❑ No restrictions, all relevant/pertinent information regarding services
- ❑ Evaluation Only
- ❑ Other:

Communication to/from these individuals may occur in a variety of ways (in person, phone conversations, email, fax, mail). Please know that you have the right to restrict how information about you or your child is shared. Kindly indicate any restrictions you wish to request regarding how information is shared with the above named individuals.

- ❑ I do not have any restrictions on how information is shared.
- ❑ I wish to apply the following restrictions:_____

_____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time. And, I also understand that such revocation must be in writing and received by Provider to be effective. Provider shall not condition services upon Client signing this authorization and Client has the right to refuse to sign this form. This form will be valid for up to one year, or until the date listed on this authorization.

This authorization shall remain valid until: _____ (not to exceed one year)

_____ _____

Client's Signature (or parent/legal guardian) Date

_____

Printed Name of person signing form