AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name: _____

Date of Birth __/__/____ Soc. Security Number: ___-__-____

By my signature below, I _____, authorize Gentry Therapy LLC and Michael A. Gentry, JD, LCSW, to exchange (both to release and receive) confidential information (whether written, oral, graphic, via mail, email, telephone, FAX, or otherwise) related to my mental health counseling, treatment, and/or psychiatric/psychological treatment, including records of testing, medication, diagnosis, assessment, and insurance records as applicable, with the following individuals and/or organizations:

1. _____
2. _____
3. _____
4. _____

These disclosures are for the purpose of my counseling, diagnosis, testing, and mental health treatment.

The extent or nature of the information to be disclosed includes all of the records or other information related to me which is in possession of Gentry Therapy LLC/Michael A. Gentry, JD LCSW, or the persons or staff of the agency or institutions named above, and includes their mental impressions, memories, beliefs, conversations, or other knowledge related to me.

This authorization expires on _____ unless revoked by me in writing prior to that date. If no date is specified, this release will expire one year from the date of my last session with Gentry Therapy LLC/Michael A. Gentry JD LCSW. I understand that I may revoke my consent to allow release of this information at any time, except to the extent disclosures have already been made in reliance on this release prior to my revocation.

Client Signature _____ Date: _____

Counselor Signature _____ Date: _____