Release of Information Consent Form

I hereby authorize: ____*

To share with and/or forward/receive information to: **COURTNEY GABLE, LPC**.

It is understood that this consent to release/receive information will expire upon written notice.

Date(s) of Treatment: ____________________________

Specific information requested includes:

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Purpose for this disclosure:

____

____

Patient Name: ____

Date of Birth: ____

Patient Signature: ____ Date: _________________

Parent/guardian signature (if applicable): ____

**Authorized provider's contact information:*

Phone: ____

Email: ____

Other: ____