



CONSENT TO RELEASE CONFIDENTIAL PATIENT INFORMATION

This consent authorizes: Lauryn Salassi Gilliam, PhD, LMFT
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to exchange all pertinent clinical information pertaining to me with:

Name: _____ Phone: _____

Address: _____

This information is needed for assessment, evaluation, and/or treatment purposes. A photocopy/fax of this Consent to Release Information is as valid as the original. I am advised of and understand my right to receive a copy of this authorization upon request.

I understand that I have no obligation whatsoever to disclose the requested information and that I may revoke this consent at any time by informing the above-named individuals in writing.

SIGNATURE OF CLIENT, PARENT OR LEGAL GUARDIAN

DATE

PRINTED NAME OF CLIENT, PARENT OR LEGAL GUARDIAN

DATE

Consent of other adults participating in session:

SIGNATURE

PRINT NAME

LAURYN SALASSI GILLIAM, PhD, LMFT