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MAKING THE CONNECTION

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