Anne Gordon, LCSW, LMFT, LAC, PC

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(406) 370-6251

Release of Information

I, _____ (printed client name), _____ (DOB), hereby give permission to Anne Gordon, LCSW, LMFT, LAC, PC, in connection with my therapy to:

[ ] Disclose Information to: _____

[ ] Obtain Information from: _____

City, State, Zip Code: _____

Phone Number: ( ) _____ Fax: ( ) _____

INFORMATION TO BE DISCLOSED OR OBTAINED VERBALLY, WRITTEN, TYPED, OR PHOTOCOPIED:

[ ] MY ENTIRE COUNSELING RECORD; OR

[ ] ONLY the following information - CLIENT MUST INITIAL EACH ITEM TO BE RELEASED OR OBTAINED:

_____ Diagnostic Impression/Assessment

_____ Attendance Records Only

_____ Expected Length of Counseling

_____ Recommendations/Plan

_____ Progress Report on Counseling

_____ Intake

_____ Other (specify): _____

The purpose for such disclosure is [ ] to permit continuity [ ] other (specify): _____

I MAY REVOKE THIS CONSENT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE UPON IT. IF I DO NOT REVOKE IT, THIS CONSENT WILL EXPIRE ONE (1) YEAR AFTER I HAVE TERMINATED TREATMENT WITH Anne Gordon, LCSW, LMFT, LAC, PC.

_____ _____ _____ _____

Client Signature/Parent if Client is a Minor Date Counselor Signature Date

NOTICE OF RECIPIENT INFORMATION: This information has been disclosed to you from records, the confidentiality of which may be protected by federal and/or state law.

DISCLAIMER: It is the legal responsibility of the recipient of this information (transmitted electronically or otherwise) to comply with HIPAA regulations.