E R I N G I L B E R T , M S W
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Release of Information Form

I, (name of client) _____**,** hereby authorize Erin Gilbert, LCSW, to release treatment information and records obtained in the course of her work with me to:

Name #1: _____

Contact Information: _____

Name #2: _____

Contact Information: _____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time though Erin may already have taken action in reliance upon it. I also understand that such revocation must be in writing and received by Erin via the above email address or the above mailing address to be effective.

This disclosure of information and records is required for the following purpose:

_____

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

This authorization shall remain valid for one year from the date provided below.

Signature of Client: _____

Printed Name of Client: _____

Date: _____