MELONIE GALE ~ MA LMFT, LPCC, LMHC, NCC
Licensed Marriage Family Counselor #46352
Licensed Professional Clinical Counselor #174
Licensed Mental Health Counselor #LH00003656
National Certified Counselor #56037

858-429-8999
3636 Fourth Ave
Suite 210
San Diego CA 92103
melgaletherapy.com

RELEASE OF INFORMATION

Client Information SS#______________________________

Name____ DOB______________________________

The above named client hereby authorizes **Melonie Gale MA** to disclose/exchange the defined subsequent information pertaining to the defined purpose(s) with the authorized recipient below. It is my understanding that this authorization can be revoked at any time, except to the extent that substantial action may have already occurred in reliance on this authorization, including provision of health care services requiring subsequent disclosure to effectuate payment. Unauthorized redisclosure by recipient is a potential risk. Client understands their right to refuse to sign this authorization and that refusal will not condition treatment, payment, enrollment or eligibility for benefits.

Authorized Recipient (s)

Name____ Affiliation________________________________

Address____ City_____________ ST_________ Zip_________

Phone____ Fax_______________________________________

If not previously revoked, this authorization will expire:____________________________________

Specific Limitation: Except as to third-party payers, this authorization does not include disclosure for future health care services received more than ninety (90) days from date of last signature.

Information to be Disclosed:

{ } Treatment Plan
{ } Health Care Information
{ } Psychiatric Evaluation
{ } Insurance

{ } Other____

Purpose for Disclosure:

{ } To permit continuity of care
{ } To permit processing of benefit claims

{ } Other____

Client Signature____ Date_____________

Witness Signature____ Date_____________

Renewal
Signature____ Date_____________