

Gayle Gonzalez-Johnson, MSW, LCSW, ACSW
Licensed Clinical Social Worker specializing in caring,
competent, therapeutic work with adult individuals & couples.

Consent for Exchange of Information

I, _____, hereby request and authorize my therapist, Gayle Gonzalez-
(Client name)

Johnson, LCSW to use or disclose to _____ the following
(Name of recipient)

confidential information: _____

for the purposes of evaluation, consultation, and/or treatment.

I understand that the means of disclosure may be by telephone, fax, postal mail, email, or in person.

I understand that privacy laws may not prohibit the recipient from re-disclosing my confidential information.

I understand that I may revoke this authorization at any time in writing, except to the extent that action has been taken in reliance on it.

This authorization expires automatically one year from the date below, if not revoked earlier.

Client Name _____ Date of Birth _____

Client Signature _____ Today's Date _____

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