AUTHORIZATION FOR RELEASE OF INFORMATION

Barbara Gold, LCSW, LMFT

14902 Preston Road, Suite 404

Dallas, Texas 75254

972-490-1669

Client Name: _____ Date of Birth: _____

I hereby request and authorize **Barbara Gold, LCSW, LMFT** to ___ release information to and/or ___release information from:

Name: _____

Phone: _____

The purpose of such disclosure is:

Authorization expires at the end of treatment or: _____

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 at the termination of treatment with either party above. I understand this information may include drug and alcohol abuse, mental health treatment, information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), laboratory test results, treatment progress and any other related information.

Notice to Recipient of Information

This information has been disclosed from records whose confidentiality may be protected by federal and state law. If the records are so protected, further disclosure of this information is prohibited unless expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted except as required by law.

Client Signature: _____ Date: _____

Printed Name (Client): _____