Gayle Gonzalez-Johnson
Psychotherapy

Consent for Exchange of Information

I _____ hereby request and authorize my therapist,

Gayle Gonzalez- Johnson, LCSW to use or disclose to _____

_____

the following 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 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 (Printed)

_____
Client Signature Date

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