Virginia Gilbert, LMFT

MFC 49578

323-528-6747
vgilbertmft@gmail.com

RELEASE OF INFORMATION

I hereby authorize an exchange and/or release of clinical information between Virginia Gilbert, LMFT and the following person(s):

Receiving entity:
____

Address:____

____

Telephone:____

Relationship to client:_________________________________

Effective dates: From:____________________ To:________________________

Purpose of Release:____

____

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Virginia Gilbert, LMFT will observe an applicable rule of confidentiality regarding any information, written or verbal, which is received under this agreement. It is understood that this exchange and/or receipt of information is intended solely for the purpose of furthering treatment.

I understand that I have a right to receive a copy of this document. A photocopy is as valid as the original document.

Print Name:____

Signature:____________________________Date:______________