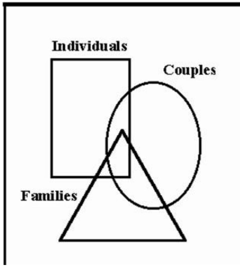

MARTIN J. GAY, MS, LPC, NCC

Individual, Marriage, Family & Adolescent Therapy
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National Certified Counselor

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Authorization for Use/Disclosure of Health Care Information

To My Clients: I can help you better if I am able to work with other agencies that know you and your family. By signing this form, you are giving permission for these organizations to share information about your situation.

Client Name: ___________________________ **Date of Birth:** ______________________

I request and authorize Martin J. Gay, MS, LPC, NCC to release the health care information described below to:

Name (and organization, if applicable)**:** ____

Address: ____

City, State, Zip Code: ____

This authorization applies to the following information:

- ☐ Diagnosis
- ☐ Clinical Assessment
- ☐ Treatment Plan
- ☐ Treatment Notes (as allowed by State Law)
- ☐ Scheduling and keeping of appointments
- ☐ Provider treatment recommendations for my care
- ☐ Information regarding compliance with recommended treatment
- ☐ Other specific information:

____

☐ **I also authorize the above party to disclose, when requested to do so by Martin J. Gay, MS, LPC, NCC, any and all information concerning myself** with respect to any illness or injury, medical history, prescription or treatment, legal history, counseling or consultation, or psychological testing and evaluation, and written copies of any medical, alcohol/drug, mental health, counseling, educational, or social service records. Alcohol/drug, mental health and medical records include all aspects of diagnosis, treatment, and prognosis. Educational records include both behavioral and progress reports.

The purpose(s) for the disclosure of such information is to: facilitate my treatment, coordinate treatment services between the above named providers, or obtain corroboration of my report of history and current behavior.

This authorization becomes effective___________(date) and may be revoked by me in writing at any time, except to the extent of action already taken. Unless earlier revoked by me, this authorization terminates twelve (12) months from the effective date. I understand that Martin J. Gay, MS. LPC, NCC may release the information authorized by this release to the authorized recipient(s) only, for the purpose(s) noted above.

Client Signature: ____

Signature of Parent or Legal Guardian: ____

Date: ____

To those receiving information under this authorization: This information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to who it pertains unless authorized by other laws.