GIL INSTITUTE
for trauma recovery & education

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL RECORDS

Regarding: _____
Client Name Date of Birth

I, the Undersigned: _____
Printed Name of Parent/Legal Guardian Phone

_____
Street Address City State Zip Code

I authorize GIL INSTITUTE FOR TRAUMA RECOVERY & EDUCATION, LLC □ to ***release*** □ **to *receive*** information pertinent to the clinical treatment of the client listed above to the persons/ agencies indicated below:

_____
Agency/Individual Name Phone

_____
Agency/Individual Name Phone

_____
Agency/Individual Name Phone

_____
Agency/Individual Name Phone

Confidential health record information for the purpose of:
_____

As the person signing this authorization, I understand that I am giving my permission to Gil Institute for disclosure and/or receipt of confidential health records. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of Gil Institute.

This consent is valid until _____. If no date is indicated the consent will expire one year from the signature date.

_____ _____
Signature of Parent/Legal Guardian/Client Print name Date

_____ _____
Witness to signature Print name Date