GAIL W. GABRIEL, MS
MARRIAGE AND FAMILY THERAPIST
LICENSE # LMFT31655

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

By signing this document, I, _____ (hereinafter "Patient" or Patient's parent/guardian) hereby authorize GAIL W. GABRIEL (hereinafter "Provider") to disclose and mutually exchange any and all mental health treatment information and records obtained in the course of Provider's treatment of _____(Patient) including, but not limited to my (or my child's) social, emotional, educational, religious, psychological and medical histories, including assessments, background, opinions, and any other relevant date necessary to assist GAIL GABRIEL in providing continuing service to myself or my child, TO:

_____ (Name) _____ (Function)
_____ (Address) _____ (Telephone)
_____ (City, State) _____ (FAX)

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at 555 Peters Avenue, Suite 230, Pleasanton, California 94566 to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose:

- ❑ Treatment planning _____
- ❑ Insurance reimbursement_____
- ❑ Educational consultation_____
- ❑ Treatment Coordination _____
- ❑ Emergency contact _____
- ❑ Other (specify) _____

I agree to indemnify and hold harmless all persons named above from any and all liability claims, actions, damages or suits arising from or relating to the release or exchange of information made pursuant to this authorization to release confidential information.

Provider shall not condition treatment upon Patient signing this authorization. Patient has the right to refuse to sign this form.

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Rule; although, such information may be protected by applicable California law.

This authorization shall remain valid until _____ or until three months following the conclusion of treatment, whichever comes first.

_____(Patient) _____ (Date)

If not signed by the patient, please indicate relationship: _____