# RELEASE OF INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you.
Please be sure to provide *all* information requested. Failure to do so may invalidate this authorization.

Name of Client: ______________________________________________ Date of Birth: _________________

Phone Number:_________________________________________ SSN: ______________________________

Patient Address:____________________________________________________________________________

City:________________________________ State:______________________ Zip:____________________

**USE AND DISCLOSURE OF HEALTH INFORMATION**

I hereby authorize: Gabriel Group Counseling, LLC. Attention: _______________________________________

16600 W. Sprague Rd Suite 245 Middleburg Heights, OH 44130 Phone: 440-523-0370 Fax: 877-524-5670

To release to and/or obtain information ___________________________________________________

Address: ______________________________________________________________________________

Phone Number: __________________________________ Fax Number: __________________________

Between the dates of _______________________________ and __________________________________

The following information:

| | | |
|---|---|---|
| □Intake Summary | □Mental Health Information | □Discharge Summary |
| □Psychological Evaluation | □Social History | □Treatment Summary |
| □Psychological Testing | □ Family History (clinical/substance) | |

**PURPOSE**

Purpose of requested use or disclosure: client request; OR other: _________________________________

**EXPIRATION**

This authorization expires on: _______________________________________________________________

Any questions related to this form or the proposed treatment can be directed to Gabriel Group Counseling, LLC at 440-523-0370.

_______________________________________ _______________________________________
Print Name of Client or Parent/Guardian Signature of Client or Parent/Guardian

____________________________________
Date