Gale & Associates, LLC.
Psychotherapy and Assessment Services

2760 W. Rasmussen Rd., Bldg D, Suite 210 · Park City, Utah · 84098

AUTHORIZATION TO RELEASE OR OBTAIN CONFIDENTIAL INFORMATION

I hereby authorize C. Maxwell Gale, Psy.D., to release, obtain or exchange specific information relative to the assessment/treatment of client,

Name: ____

Date of Birth: ______________________

C. Maxwell Gale Gale Psy.D. may: (Check one)

Obtain • Release • Exchange (obtain/release) •

Information with the following professional:

Name: ________________________________ Title: ________________

Organization Name & Address: ___________________________________

____
Street City State Zip

Phone: ____________________ Fax: _______________________

THE FOLLOWING SPECIFIC INFORMATION IS TO BE RELEASED/OBTAINED

____ Verbal Contact
____ Discharge Summary
____ Psychiatric Evaluation
____ History & Physical
____ Psychological Assessment
____ Court/Police Records
____ Other (specify) ____________________________________
____ Psychosocial Evaluation
____ Adjunctive Therapy Evaluation
____ Educational Evaluation/Credits
____ Treatment Plan
____ Aftercare Plan
____ Treatment Progress

Information is to be obtained for the purpose of: (Check all that apply)

Assessment • Treatment Planning • Continuing Treatment •

Other: ____ •

I _________________________, (Client) __________________________ (Parent/Guardian) understand the information to be disclosed is limited to the criteria defined above. Obtaining or releasing additional information may not occur without written consent to do so. Consent is subject to revocation at any time in the form of written notice from the client, or parent/guardian when applicable. Without revocation, this consent will expire six (6) months after termination/completion of services. I waive and release C. Maxwell Gale, Psy.D., from any liability resulting from the release/obtaining/exchange of the above information.

Client ______________________Date __________ Parent/Guardian ____________________ Date________

Witness__________________________________ Date ______________