ROBIN M. GILMORE, LCSW, LLC
Release of Information Authorization

I, _____, date of birth, _____,
authorize Robin M. Gilmore, LCSW, LLC, to disclose to and/or obtain from:
_____
_____

the following information: _____

Purpose: Coordination of treatment/continuity of care unless otherwise stated here:

_____

Revocation: I understand that I have the right to revoke this authorization, in writing, at any time by sending a written request notification to Robin M. Gilmore, LCSW, LLC, 4660 Kenmore Ave, Suite 701, Alexandria, VA 22304. I further understand that a revocation of this authorization is not effective with regards to any prior authorized communication that has occurred in reliance on this authorization.

Expiration: Unless sooner revoked, this consent expires on the following date: _____.
If a calendar date is not stated, information may only be released on the date the authorization is received.

Conditions: I further understand that Robin M. Gilmore, LCSW, LLC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

_____

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, I reserve the right to disclose information as permitted by this authorization in any manner that I deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

Redisclosure: State and Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by written authorization of _____.
(client name)

_____
Signature of Client Printed Name Date

_____
Signature of Parent or Guardian Printed Name Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (parent, power Of attorney, etc.):_____

Signature of Witness_____Date_____

Client elected to revoke release (date)_____Staff Signature_____