

Allison C. Gary, MA, LPC, NCC
Grief Counselor
AllisonCGary@gmail.com
Direct: 720-619-1058



Release of Information

I, _____, authorize Allison C. Gary of ACG Counseling Services, independent contractor to Ipseity Counseling Clinic to use and disclose the protected health information described below to

_____ person/agency,
at telephone number _____
email address: _____
mailing address: _____

This authorization for release of information covers the period of healthcare from the dates _____ to _____ or all past, present, and future periods of service. I authorize the release of:

my complete health care record to include any mental healthcare, communicable diseases, treatments of substance abuse, and services received with Allison C. Gary of ACG Counseling Services, independent contractor at Ipseity Counseling Clinic

OR

my health records except for the following information: _____

For the purposes of: _____

I understand that this information may be used for treatment collaboration or consultation or other purposes as I may direct. I authorize this release to be effective until: _____ (date or event), at which time this authorization will expire. If a date is not specified, this authorization will expire 60-days from signature date. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that services received with Allison C. Gary of ACG Counseling Services, independent contractor at Ipseity Counseling Clinic are not conditioned on whether I sign this authorization.

Printed Name	Client/Responsible Party Signature	Date
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Allison C. Gary, MA, LPC, NCC		Date
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