Authorization for Release of Confidential Information

I hereby authorize Randy A. Gilchrist, Psy.D., and staff, and the persons or entities listed below, or their representatives, to mutually release and disclose my health information.

I understand that by signing this General Authorization I am authorizing Randy A. Gilchrist, Psy.D., and staff, to disclose my health information to the persons and entities listed below and that any confidential information in possession of the persons and entities listed below may also be disclosed to Randy A. Gilchrist, Psy.D., and staff.

My health information includes, without limitation, any records, reports, test results, opinions, assessments, and/or any other information related to medical, emotional, educational, or psychological conditions. Disclosure may also be made to describe my condition and progress, to discuss treatment, and/or to coordinate with any person or entity providing any payment for services I receive.

I understand and agree that I may revoke this consent at anytime in writing. This consent will become null and void 6 months after the final session attended with Randy A. Gilchrist, Psy.D., or 1 year after the signing of this document (whichever comes second).

I waive any right of privacy that I may have in connection with the disclosures hereby authorized to the following persons and/or entities:

_____	_____	_____
Person or Entity	_____	Client's Initials
	_____	
	_____	
	Address and Phone Number (if available)	
_____	_____	_____
Person or Entity	_____	Client's Initials
	_____	
	_____	
	Address and Phone Number (if available)	

_____ _____

Client's Signature Date

_____ _____

Parent or Guardian's Signature (if client is under 18 yrs. old) Date

_____ _____

Witness's Signature Date