

MARTIN J. GAY, MS, LPC, NCC

Individual, Marriage, Family & Adolescent Therapy

Licensed Professional Counselor

National Certified Counselor

1335 Cannon Street, SE

Salem, Oregon 97302

Phone: 503-375-6362

Fax: 503-581-6046

mg@martingay.com

www.martingay.com

RELEASE OF INFORMATION

To Whom It May Concern:

I, _____, (Date of Birth) ____/____/____
 (Name of Client) M D Y

hereby authorize: _____
 (Name of Organization and/or Person to Release the Information)

to disclose, when requested to do so by Martin J. Gay, MS, LPC, NCC, any and all information concerning myself with respect to any illness or injury, medical history, prescription or treatment, legal history, counseling or consultation, or psychological testing and evaluation, and written copies of any medical, counseling, or social service records.

I also authorize Martin J. Gay, MS, LPC, NCC, to disclose any and all information to the above organization and/or person.

The only purpose(s) for the disclosure of such information is to: facilitate client's treatment, coordinate treatment services with the above named provider, or obtain corroboration of client's report of history and current behavior.

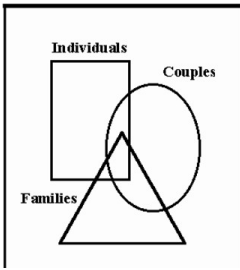
I may cancel this consent of information release at any time. This document will automatically be null and void 60 days after termination of treatment with Martin J. Gay, MS, LPC, NCC.

A photostatic copy of this authorization shall be considered as effective and valid as the original.

Client Signature _____

Signature of Parent
 or Legal Guardian _____

Date _____



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Authorization for Use/Disclosure of Health Care Information

Client Name: _____ **Date of Birth:** _____

Previous or Other Name (if applicable): _____

I request and authorize Martin J. Gay, MS, LPC, NCC to release the health care information described below to:

Name (and organization, if applicable): _____

Address: _____

City, State: _____ **Zip Code:** _____

This authorization applies to the following information: _____

during the following time period: _____

The purpose of the disclosure is as follows: _____

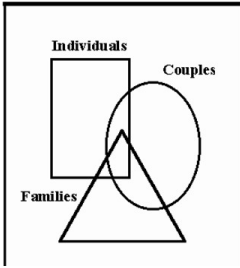
[In the description of information to be released, it is acceptable to provide a checklist of items commonly released in the particular practice, including a category marked "Other". In describing the purpose, it is acceptable to include the statement "at the request of the individual" when a client or his/her personal representative elects not to provide a statement of the purpose.]

This authorization will expire on: _____ [specify date or event].

I understand that I have the right to revoke this authorization by making a written request to Martin J. Gay, MS, LPC, NCC.

I understand that Martin J. Gay, MS, LPC, NCC may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization, unless: 1) my treatment is related to research and the purpose of this authorization is to permit the information listed above to be used for research purposes; or 2) the services I am receiving are solely for the purpose of creating protected health information for disclosure to a third party (e.g., an independent evaluation). If one of these exceptions applies, the consequences to me of refusing to sign the authorization are: _____

I understand the potential for the information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient. If this occurs, the information may no longer be protected by federal privacy



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regulations. [Note: State law may prohibit re-disclosure of certain mental health information without written authorization.]

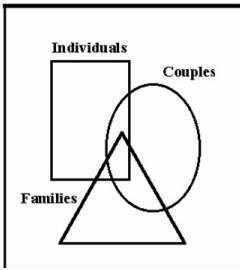
I understand that my express consent is required to release any health care information related to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorder/mental health or drug/alcohol treatment or use. [State law may impose additional requirements.]

Signature (client/patient or authorized personal representative): _____

Relationship or authority (if signed by authorized personal representative): _____

Date: _____

[Copy of authorization should be given to client/patient or personal representative]



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