



**MARTIN J. GAY, MS, LPC, NCC**

*Individual, Marriage, Family & Adolescent Therapy*

Licensed Professional Counselor  
National Certified Counselor

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**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, M.S., 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, M.S. 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, M.S.

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 \_\_\_\_\_