



## Release of Confidential Information

Today's Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I hereby authorize Gobbel Counseling & Adoption Services, PLLC to (check either or both boxes)

obtain information from

release information to

Agency \_\_\_\_\_

Attention \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Telephone \_\_\_\_\_

Email \_\_\_\_\_

Information to be obtained/released/exchanged:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Diagnosis         | <input type="checkbox"/> Case Summary               | <input type="checkbox"/> Assessments          |
| <input type="checkbox"/> Treatment Plan    | <input type="checkbox"/> Psychological Test Results | <input type="checkbox"/> CPS Case Information |
| <input type="checkbox"/> Progress Reports  | <input type="checkbox"/> Court Orders               | <input type="checkbox"/> Other: _____         |
| <input type="checkbox"/> Treatment Summary | <input type="checkbox"/> Education/School Records   | <input type="checkbox"/> Other: _____         |

**Gobbel Counseling & Adoption Services, PLLC is not responsible for any information once it has been released to a third party.**

This release of information automatically terminates when the family terminates when the family terminates services with Gobbel Counseling & Adoption Services, PLLC unless previously revoked.

Parent/Guardian \_\_\_\_\_  
Printed Name

Parent Guardian \_\_\_\_\_  
Signature

\_\_\_\_\_ Date

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