Informed Consent for Treatment & Information

Welcome! This packet contains important information regarding your sessions with Holly Gilbert, MA, LPC, therapist. Please read carefully and retain for your records.

Entering therapy requires a commitment of time, energy and resources, and often requires some courage to make the first appointment. Your commitment will be honored here and you will be treated with respect. While you will leave some sessions feeling better, you will end others feeling emotionally tired. We admire you for engaging in this personal growth and healing process. Please review the following materials in advance of your first session.

Sessions, Fees, & Insurance
Individual and couples therapy sessions are typically 45 minutes. **Fees must be paid at the time of session (individual therapy sessions are $115.00, Family therapy sessions are 150)** There are no exceptions to this policy. For your convenience, you may keep a credit card on file to be run on the day of your session. Checks are to be made payable to Holly Gilbert LLC**.**

If you have a session with more than one therapist, regardless of who asks for the meeting (you or the therapist) you will be billed as follows: The primary therapist is charged at full fee. Additional therapists are charged at a reduced fee. The second therapist in the session may not be covered/reimbursed by your insurance company.

Insurance: It is the sole responsibility of the client to determine which services provided by your therapist are reimbursable by your health insurance. The client is encouraged to inquire into insurance coverage at the outset of treatment. Your therapist is not responsible for determining coverage in any form including pre-existing condition, duration of coverage, and particular provider credentials.

While insurance forms and receipts can be provided to you, it may be to your benefit to not use any insurance benefits, due to the following reasons: 1) PRIVACY. Many insurance companies ask for your complete medical record and this is kept in their computer database. We have no control over how this information is used or who has access to it. Therefore, we cannot guarantee confidentiality on any information released to your insurance company. 2) You have complete CONTROL (except the standard confidentiality exceptions) over all information about you, who has it and what is done with that information. 3) You receive NO psychological DIAGNOSIS that anyone else is aware of (when you use insurance a diagnosis has to be submitted to them). 4) You have CONTROL over the frequency of your sessions and how long you feel you need to come.

Cancellations and Missed Appointments
If you find it necessary to cancel a scheduled appointment, 24 hours' notice is required by contacting Holly Gilbert. **When less than 24 hours' notice is given, you will be responsible to pay the session fee.** Missed appointment fees are not covered under any insurance.

Client's Rights
You have a right to competent and professional service. You have the right to be treated with respect. You have the right to a therapeutic relationship without physical, sexual, verbal or other abuse or exploitation. You have the right to file a complaint. You have a right to evaluate our services. You have a right to request to modify, review or release your clinical file. You have a right to be given a referral to a different therapy provider if the terms or costs of these services are not agreeable to you.

Confidentiality
Federal and Ohio law require that issues discussed with a therapist be confidential. The information you reveal will not be discussed by the therapist with anyone without a signed authorization from you. Your right to strict privacy will be protected.

The release of confidential materials may be legally required of your therapist in the following situations: 1) If your therapist believes you present a clear and substantial risk of imminent serious harm to yourself (suicide) or others (homicide); 2) Suspected child or elder abuse or neglect; 3) Instances where the court subpoenas records; and 4) If you file a complaint or lawsuit against Holly Gilbert LLC.

Litigation
Holly Gilbert LLC, is a therapeutic practice that does not and does not want to provide forensic services. We feel that this jeopardizes the therapeutic alliance. Included in this packet is an anti-litigation form, which you will be asked to sign even if you are NOT currently in litigation. This form becomes part of the file.

Emergencies
In the event of an emergency involving threat to self or others please go directly to a hospital emergency room or call 911. Emergencies are urgent issues requiring your immediate action. Our general philosophy regarding emergencies is that clients are assumed to be self-responsible (i.e. autonomous, functioning, not in need of day to day supervision). In addition, as private practice clinicians we cannot assume responsibility for our client's day to day functioning as can an institution nor can we be available for 24-hour per day crisis care.

Communication
Email and text messaging for communication are discouraged. If you decide you want to utilize email and/or text messaging as forms of communication between you and your therapist, you acknowledge that there are risks inherent in such communications and you accept those risks.

Text messaging via mobile phone is acceptable for appointments and housekeeping issues only. Names are not stored in your therapist's phone. If you call your therapist's mobile phone, please be aware that unless you are both on land line phones, the conversation is not confidential. Any computer files referencing our communication are maintained using secure and encrypted measures. We will not respond to personal and clinical concerns via regular email or text messaging. You understand that emails between sessions that contain confidential information will be sent via encryption.

Group Consultation
Your therapist participates in group consultation sessions with licensed mental health professionals on a weekly basis. This is a common and encouraged practice among mental health professionals.

Incapacity or Death of Therapist
In the event that your therapist is incapacitated or dies, it will be necessary for another therapist to take possession of your file and records. By signing this form, you consent to allow another licensed mental health professional whom your therapist designates to take possession of your file and records, to provide you with copies upon request, or to deliver them to a therapist of your choice. In signing this form below you agree that you will select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional if you choose that option.

Previous Treatment
If you have participated in a therapeutic experience prior to coming to Holly Gilbert LLC, please request an Authorization to Release of Information form to submit to your previous provider. Your records cannot and will not be sent without your approval.

Acknowledgement of Informed Consent to Treatment & Notice of Privacy Practices

Client/Legal Guardian Name: _____ Date of Birth_____

Child's Name_____ Date of Birth_____

I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize Holly Gilbert LLC, to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment, or services that I receive through Holly Gilbert LLC, at any time. I also understand that there are no guarantees that treatment will be successful.

By signing this Acknowledgement of Informed Consent to Treatment, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein and I agree to be bound by the provisions in this agreement. I have been offered a copy of the Acknowledgement of Informed Consent to Treatment. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me. If a minor is the client, I am signing on behalf of the minor as the authorized parent/guardian. (Information on minor rights will be shared with the minor.)

I acknowledge that I have received an opportunity to review the Notice of Privacy Practices of Holly Gilbert LLC. I further acknowledge that a copy of the Notice of Privacy Practices has been offered to me.

I have read the above and understand and agree to my responsibilities. I acknowledge that by signing this Acknowledgement of Informed Consent to Treatment, I give consent and such consent will continue until I withdraw consent by providing written notice of such withdrawal to Holly Gilbert LLC, at 465 Waterbury Court, Gahanna, Ohio 43230. If minor client, parent/legal guardian attests to having legal custody and consents to fees and treatment by this signature.

Client/Legal Guardian Signature_____ Date_____

Witness_____ Date_____

HOLLY GILBERT, LLC
465 Waterbury Court, Gahanna, Ohio 43230
Phone 614-751-5393 * Fax 614-751-5394

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We are committed to protecting health information about you by complying with all applicable federal and state privacy and confidentiality laws and regulations. These laws require that health information that identifies you is kept private and confidential. These laws also require that we give you this notice of our legal duties and privacy practices with respect to health information about you, and that we follow the terms of the notice that is currently in effect.

I. Uses and Disclosures WITH Your Authorization

Generally, we will use or disclose your health information only when you give your authorization in writing for us to do so. You may revoke your authorization except to the extent that we have already taken action upon the authorization. There are some exceptions and special rules that allow for uses and disclosures without your authorization or consent, which are set forth below.

II. Uses and Disclosures WITHOUT Your Authorization

All Protected Health Information Even when you have not given your written authorization, we may use and disclose information under the circumstances listed below.

a. Treatment. We may use or disclose health information about you for treatment purposes. Treatment includes diagnosis, treatment and other services, including discharge planning. For example, if your therapist decides to consult with another health care provider about your condition, your therapist would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist your therapist in the diagnosis or treatment of your mental health condition. In addition, therapists may disclose your health information to each other to coordinate individual and group therapy sessions for your treatment or to discuss information about treatment alternatives or other health-related benefits and services that are necessary or may be of interest to you.

b. Payment. We may use and disclose health information about you so that the services you receive may be billed to and payment may be collected from you, an insurance company, or another third party. For example, if your health plan requests a copy of your health records, or a portion thereof, in order to determine whether or not payment is warranted under the terms of your policy or contract, we are permitted to use and disclose your personal health information. We may also tell your health plan about a services you are going to receive, to obtain prior approval or to determine whether your plan will cover the rest of the services.

c. Health Care Operations. We may use or disclose health information about you for the purposes of health care operations that include internal administration and planning and various activities that improve the quality and effectiveness of care. For example, if your health plan decides to audit Holly Gilbert LLC, in order to review our competence and our performance, or to detect possible fraud or abuse, your health information may be used or disclosed for those purposes. Sometimes we my hire outside parties to help us carry out certain health care operations, such as computer maintenance performed by outside companies. If such outside parties will have any access to your health information when they are performing their jobs, we will require that they appropriately safeguard your information. This list of examples is for illustration only and is not an exclusive list of all of the potential uses and disclosures that may be made for health care operations.

d. Appointment Reminders, Treatment Alternatives, and Additional Services. We may use or disclose health information about you to provide appointment reminders or to provide you with information about treatment alternatives or other health-related benefits and services that may be of

interest to you. Be sure to let me know where and by what means (e.g., telephone, letter, email, fax) you may be contacted.

e. When Required By Law. We may use or disclose health information about you as required by state or federal law. For example, we may disclose such information in the following circumstances:

- **i.** If disclosure is compelled by a court pursuant to an order of that court
- **ii.** If disclosure is compelled by a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority
- **iii.** If disclosure is compelled by a party to a proceeding before a court or administrative agency pursuant to a subpoena, subpoena duces tecum (e.g., a subpoena for mental health records), notice to appear, or any provision authorizing discovery in a proceeding before a court or administrative agency.
- **iv.** If disclosure is compelled by a board, commission, or administrative agency pursuant to an investigative subpoena issued pursuant to its lawful authority.
- **v.** If disclosure is compelled by an arbitrator or arbitration panel, when arbitration is lawfully requested by either party, pursuant to a subpoena duces tecum (e.g., a subpoena for mental health records), or any other provision authorizing discovery in a proceeding before an arbitrator or arbitration panel.
- **vi.** If disclosure is compelled by a search warrant lawfully issued to a governmental law enforcement agency.

f. When Compelled or Permitted By Law in Certain Circumstances. We may use or disclose health information about you when compelled or permitted by state or federal law in the following circumstances:

- **i. For Health or Safety of You or Others.** We may disclose your health information to avert or lessen a serious threat of harm to you, to others, or to the public. We may be compelled to disclose your health information where you have made a specific threat of serious physical harm to another specific person or the public, and disclosure is otherwise required under statute and/or common law.
- **ii. Child Abuse or Maltreatment of Vulnerable Adults**. We may disclose your health information for the purpose of reporting child abuse and neglect, or the maltreatment of vulnerable adults, to public health authorities or other government authorities authorized by law to receive such reports.
- **iii. Commission of a Crime.** We may disclose your health information to the police or other law enforcement officials if you commit a crime on the premises or against an employee or agent of Holly Gilbert LLC, or threaten to commit such a crime.
- **iv. Death.** We may disclose your health information to a coroner, medical examiner or other authorized person in the event of your death in order to determine the cause of your death.
- **v. Authorized Representatives**. We may disclose your health information to a person appointed by a court to represent or administer your interests.
- **vi. Department of Health and Human Services**. We may disclose your health information to the United States Department of Health and Human Services when disclosure is compelled or permitted to investigate or determine my compliance with privacy requirements under the federal regulations (the "Privacy Rule").

III. Your Individual Rights

a. Right to Receive Confidential Communications. Normally we will communicate with you through the phone number and address that you provide to us. If you desire us to use alternative methods of communication, you may provide us with a written request, and we will attempt to accommodate any reasonable request, for alternative means of communications or for alternative

locations where you wish to receive our communications.

b. Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of health information about you, such as those necessary to carry out treatment, payment, or health care operations. We are not required to agree to your requested restriction. If we do agree, we will maintain a written record of the agreed upon restriction.

c. Right to Inspect and Copy Your Health Information. You have the right to inspect and copy health information about you by making a specific request to do so in writing. This right to inspect and copy is not absolute – in other words, we are permitted to deny access for specified reasons. For instance, you do not have this right of access with respect to my "psychotherapy notes." The term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical (includes mental health) record. The term excludes counseling session start and stop times, the modalities and frequencies of treatment furnished, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

d. Right to Amend Your Records. You have the right to amend your health information in our records by making a request to do so in a writing that provides a reason to support the requested amendment. This right to amend is not absolute – in other words, we are permitted to deny the requested amendment for specified reasons. You also have the right, subject to limitations, to provide us with a written addendum with respect to any item or statement in your records that you believe to be incorrect or incomplete and to have the addendum become a part of your record. If your requested amendment to your records is accepted, a copy of your amendment will become a permanent part of our records. When we "amend," a record, we may append information to the original record, as opposed to physically removing or changing the original record.

e. Right to Receive an Accounting of Disclosures. You have the right to receive an accounting from me of the disclosures of protected health information made by Holly Gilbert in the six years prior to the date on which the accounting is requested. As with other rights, this right is not absolute. In other words, we are permitted to deny the request for specified reasons. For instance, we do not have to account for disclosures made in order to carry out our own treatment, payment or health care operations. We also do not have to account for disclosures of protected health information that are made with your written authorization. If you request an accounting more than once during a twelve (12) month period, there will be a charge. You will be told the cost prior to the request being filled.

f. Right to Receive a Paper Copy of This Notice. Upon request, you may obtain a paper copy of this notice.

IV. Effective Date and Right to Change the Notice

a. Effective Date. This notice is effective on April 1, 2018.

b. Right to Change Terms of This Notice. We reserve the right to change the terms of this notice and/or my privacy practices and to make the changes effective for all protected health information that we maintain, even if it was created or received prior to the effective date of the notice revision. If we make a revision to this notice, we will make the notice available at my office upon request on or after the effective date of the revision and I will post the revised notice in a clear and prominent location.

V. **Contact Person for Information or to Submit a Complaint**

a. **Contact Persons.** If you have any questions regarding this notice, please contact Holly Gilbert, MA, LPC, at 614-751-5393.

b. **Where to Submit a Complaint.** If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, contact:

Counselor, Social Worker and Marriage & Family Therapist Board
77 South High Street, 24th Floor, Room 2468
Columbus, Ohio 43215-6171
Phone 614-466-0912

****

Client Information Form - Adult

Demographic Information

_____ _____ _____ _____

Today's Date *Name (first, middle, last)* *Date of Birth* *Age*

_____

Address *City* *State* *Zip*

_____ _____

Primary Phone *Current Employer/School*

_____ _____ _____

Emergency Contact Name *Relationship* *Phone*

Veteran? ___No **___** Yes–Branch of Military_____ Time of Service_____

Gender: ___Female ___Male ___Transgender ___Other_____

Sexual orientation: ___Bisexual ___Gay ___Heterosexual ___Lesbian ___Queer ___Questioning ___Other_____

Description of Presenting Problem & Psychological History

In your own words, describe what brings you here: _____

_____

What do you want to work on or change through therapy? _____

_____

What important things have happened to you or your family in the past six months? _____

_____

What concerns/symptoms contributed to you coming in today? *Please check all that apply.*

__academic concerns
__addiction
__alcohol and/or drugs
__anxiety/worry
__career concerns
__compulsive behaviors
__depressed mood
__difficulty concentrating
__difficulty making friends
__distrust
__easily distracted
__experienced a traumatic event
__experiencing discrimination
__fatigue/loss of energy
__feeling manipulated or controlled
__feelings of worthlessness
__fear of specific places/objects
__financial concerns
__gay/lesbian/bisexual/transgender concerns
__grief
__hearing voices
__inability to control thoughts
__irritable, angry, hostile feelings
__issues with food/weight/appetite
__loneliness
__loss of significant person
__nightmares
__numbness/lack of emotion
__obsessions
__parental alcohol/drug abuse
__physical symptoms (headaches, stomach pains, rapid heartbeat, dizziness, muscle tension, etc.)
__procrastination/lack of motivation
__racial/ethnic identity
__relationship with a friend/roommate
__relationship with romantic partner
__relationship with parents/family
__self-esteem, self-confidence
__self-harm behaviors (cutting, burning, etc.)
__sexual concerns (pain during intercourse, erectile dysfunction, libido, etc.)
__shyness/being assertive
__sleep difficulties
__specific issues to discuss only with counselor
__spiritual/religious concerns
__stressed/under pressure
__suicidal feelings/behavior
__test anxiety or speech anxiety
__withdrawing from friends/ family/social activities
__other_____

HOLLY GILBERT, LLC
465 Waterbury Court, Gahanna, Ohio 43230
Phone 614-751-5393 * Fax 614-751-5394

How long have these been concerns/symptoms for you?_____

What has been helpful to you in dealing with these concerns/symptoms? _____

_____

Have you had any suicide attempts? ___Yes ___No

Have you ever had treatment by, or are you currently seeing, a psychiatrist or therapist? ___Yes ___No

Medical Information

Chronic health problems or disabilities we should be aware of? _____

Recent medical problems? _____

Current medications:_____

Substance Use

Do you feel you are addicted to anything (i.e. work, sex, alcohol, drugs, exercise, food)? __ Yes ___No

If yes, please describe:_____

Have you ever felt the need to cut down on your drinking and/or drug use? ___Yes ___No

Has anyone ever expressed concern about your alcohol and/or drug use? ___Yes ___No

If so, have you found those questions annoying or intrusive? ___Yes ___No

Do you use alcohol and/or drugs to *(check all that apply)*: ___Manage stress ___To relax ___To change mood ___For sleep

Family/Household/Relationship Information

Were you adopted? ___Yes ___No

Have any members of your family had problems with: ___Drugs ___Alcohol ___Depression ___Anxiety ___Other mental illness

Have you ever experienced: *(please mark all that apply):* __Emotional Abuse __Physical Abuse __Sexual Abuse __Sexual Assault

Are you: __Dating __Divorced __Married __Partnered __Single __Widowed __Other_____

If applicable, please describe your current relationship by placing an "X" on the line below:

No problems *Minor concerns* *Moderate concerns* *Serious concerns*

How long have you been in the relationship? _____

If you are involved with parenting any children, please list the following:

Name	**Age**	**Name**	**Age**
_____		_____	
_____		_____	
_____		_____	

If there is anything else you would like us to know that will help us best assist you, please describe below:

How did you learn about (check one) ___Gestalt Columbus and/or ___Holly Gilbert MA, LPC?

___Social media (Facebook, Instagram, LinkedIn, etc.) ___Friend ___Therapist ___Medical provider ___Internet search
___Workshop ___Employer ___School professional (teacher, school counselor, etc.) ___Other_____

PLEASE READ THE FOLLOWING CAREFULLY

1. **24-Hour Notice of Cancellation** – Like any other professional whose billing is done on an hourly basis, I have opportunity cost associated with cancellations that occur without much notice. If you are unable to keep your scheduled appointment or group meeting, you MUST notify me 24 hours in advance or you will be charged for the appointment or meeting time. Should your appointment be scheduled on a Monday, call our office number ***614-751-5393*** during the weekend and leave a voicemail noting your cancellation. There are NO exceptions.

2. **Payment for services is due at the time services are rendered**. I accept cash, Mastercard, Visa, American Express, Discover Card, HSA, or personal checks made payable to Holly Gilbert LLC. I will not see you or your child until payment is rendered before the session begins. There are NO exceptions.
3. Holly Gilbert, MA, LPC and Holly Gilbert LLC are dedicated to providing the highest quality psychotherapy services available. To that end, it is sometimes necessary to review records, discuss your situation with previous professionals, or meet with others. Especially in the case of child or family therapy, numerous visits and calls to the school, teachers, minister, etc. may be necessary. While I try to include these costs in my standard billing when possible, special meetings or protracted phone consultations may require a fee. Please be assured that I will do everything possible to minimize these special fees. I will be happy to discuss fees, insurance, and payments with you -- please do not hesitate to call me if you have any questions.

4. HOLLY GILBERT, MA, LPC and HOLLY GILBERT LLC are a therapeutic organization that does not and does not want to provide forensic services. We feel that this jeopardizes the therapeutic alliance. Included in this packet is an anti-litigation form, which you will be asked to sign even if you are NOT currently in litigation. This form becomes part of the file.

5. I have a special team approach to child psychotherapy. I am dedicated to providing a safe environment for your child to work out his/her emotional concerns. This requires your child to form a special relationship with me. In order to protect this special relationship, it is necessary to make sure that financial arrangements do not interfere with the treatment of the relationship. To optimize the treatment, please choose one of the following options for payment.
   a) Personal/parental payment at the time of session. The parent, rather than the child, is responsible for paying the fee. This will be done using a direct payment point of sale device (i.e. Square).
   b) Advance payment/Keeping a payment form on file. Parents are also welcome store a credit card on file which is run before each session. This is done through a secure payment platform called IvyPay. Insurance forms and receipt(s) can be mailed automatically as needed.

***** DO NOT CALL THE NUMBER THAT SHOWS UP ON CALLER ID *****

PLEASE CALL 614-751-5393 FOR ALL CALLS. IF YOU CALL ANY OTHER NUMBER THAT DISPLAYS ON YOUR CALLER ID, IT WILL NOT CONNECT YOU TO ME. IF YOU ARE HAVING AN EMERGENCY, PLEASE GO TO YOUR LOCAL EMERGENCY DEPARTMENT.

I HAVE READ AND UNDERSTOOD THE ABOVE FINANCIAL STATEMENT AND AGREE TO THE PAYMENT TERMS HEREIN SET FORTH. I AM RESPONSIBLE FOR PAYMENT FOR ALL SERVICES RENDERED, INCLUDING LATE CANCELS AND NO SHOWS. I FURTHER UNDERSTAND THAT IF I LIST A THIRD PARTY AS RESPONSIBLE FOR PAYMENT, AND THEY DO NOT PAY, I AM STILL RESPONSIBLE FOR ANY MONIES DUE TO HOLLY GILBERT LLC

Print Name of Responsible Party:_____

Signature of Responsible Party:_____ Date: _____

Witness: _____ Date: _____

(PRINT CLIENT NAME; if different than responsible Party)_____

Responsible Party Billing Address:_____

City:_____ State:_____ Zip:_____

Number(s) we may contact responsible party(indicate if # is work, home or cell)_____

HOLLY GILBERT, LLC
465 Waterbury Court, Gahanna, Ohio 43230
Phone 614-751-5393 * Fax 614-751-5394

Request for Communication

Client/Legal Guardian Name_____ Date of Birth_____

Name of Client (if they are a minor)_____Date of Birth_____

1. Please call and/or text me at the following numbers regarding appointments, payments/billing, and cancellations:

   Cell Phone _____ May we leave a message? ___Yes ___No
   May we send text messages? ___Yes ___No

   Home Phone _____ May we leave a message? ___Yes ___No
   May we send text messages? ___Yes ___No

   Work Phone _____ May we leave a message? ___Yes ___No
   May we send text messages? ___Yes ___No

2. Please direct all postal mail to this address: _____

   _____

3. Please list anyone who will call us to schedule/cancel/confirm appointments, make payments on your account, bring clients to their appointment, etc. (be sure to list your spouse, children, parents, assistants, babysitters/nanny, etc.)

   Name_____ Relationship to you_____
   Phone Number_____

   Name_____ Relationship to you_____
   Phone Number_____

   Name_____ Relationship to you_____
   Phone number_____

4. If you choose to communicate with your therapist via email or text messaging, please know that email and text messaging are only appropriate for scheduling and housekeeping purposes. Email and text messaging are not for clinical issues, due to the lack of confidentiality. Please note: • Any computer files referencing our communication are maintained using secure and encrypted measures. • You and your therapist will not respond to personal and clinical concerns via email or text.

Client/Legal Guardian Signature_____ Date_____

HOLLY GILBERT, LLC
465 Waterbury Court, Gahanna, Ohio 43230
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Authorization to Release Confidential Information

Client_____ Date of Birth_____

I understand that my records contain information about my/my child's counseling sessions and mental health. I understand that all of my records are protected by state and federal laws that require they be kept confidential and require my written consent to disclose. This release authorizes Holly Gilbert, MA, LPC, of Holly Gilbert LLC, to discuss these matters with those individuals or the personnel of those facilities. This disclosure is for confidential records held by other individuals or other personnel at other locations and that this release authorizes Holly Gilbert, MA, LPC, to discuss matters pertaining to those confidential records with those individuals and personnel. NOTE: It is strongly recommended that you release the least amount of information necessary to meet your intended goals.

I, _____, hereby authorize Holly Gilbert, MA, LPC, to:

____Release to
____Exchange with
____Request from

the individual or facility set forth below.

Individual's Name_____

Facility _____ Contact Person_____

Address_____

City/State/Zip_____

Telephone_____Fax_____

___ All psychological, diagnostic, treatment, and other health care information
___ All information pertinent to comprehensive treatment planning
___ Social history
___ Treatment summary
___ Observations and recommendations
___ Results and interpretations of psychological testing
___ School records and impressions
___ Medical evaluations and impressions
___ Other: _____

Parent Name (if minor) (print) _____

Address_____

I understand that I have the right to revoke this release at any time by notifying the counselor in writing. This release will expire on _____ or 90 days from the date this form was signed. I have been informed and understand this authorization to release records and information, the nature of listed content that I am willing to release, and the implications of their release. This request is voluntary.

_____

(signature of client or person authorized to consent) (date)

_____

(witness)

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