MICHAEL J. GIALANELLA, MS, LMFT
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AUTHORIZATION TO EXCHANGE INFORMATION

I, (your/minor's name) _____, hereby authorize Michael J. Gialanella, MS, LMFT, to exchange written and verbal mental health treatment information and records obtained in the course of psychotherapy treatment, to the following persons and/or parties via (mark all that apply) ☐ phone ☐ secured email:

Name	Relationship to Client	Location	Contact information
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I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Michael J. Gialanella, MS, LMFT has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Michael J. Gialanella, MS, LMFT at 8522 Six Forks Road, Suite 103 Raleigh, NC 27615 to be effective.

This disclosure/exchange of information and records is authorized for the following purpose(s):

- ☐ Notification of beginning and/or ending of treatment
- ☐ Periodic summary of progress
- ☐ Coordination of service/treatment planning
- ☐ Educational information/records
- ☐ Past treatment
- ☐ Psychological/Psychiatric Evaluation
- ☐ Financial Information/Payment arrangements
- ☐ Other (specify):_____

This consent for release of information is given freely, voluntarily and without coercion. Any information I authorize other individuals to release to Michael J. Gialanella, MS, LMFT will be held strictly confidential and will not be released without my written permission except as permitted by State or Federal law. This authorization is effective for one year from the date below, or as long as the case remains open, whichever lasts longer.

_____	_____	_____
Client/Guardian Name	Signature	Date
_____	_____	_____
Client/Guardian Name	Signature	Date
_____		_____
Witness: Michael J. Gialanella, MS, LMFT		Date