Robyn S. Gruber, MA, LPC
Trillium Springs Counseling
1640 Powers Ferry Road, Building 16, Suite 100
Atlanta, Georgia 30067
678.665.8455
RobynGruberLPC@gmail.com www.RobynGruberLPC.com

Consent for Release of Information

I, _____, hereby request that Robyn S. Gruber, LPC
(Client's name or Guardian) **(Client's Counselor)**

Circle all that apply: release to obtain from

_____
Person, place, or institution

_____
Street Address **City** **State** **Zip**

_____ _____
Phone # **Fax #**

A report of my participation in treatment. This may be by telephone or in writing.

I understand that I have no obligation whatsoever to disclose the requested information and that I may revoke this consent at any time by informing, in writing, my counselor. I further understand that this authorization is valid for as long as my counselor is involved in my care in any way, or until I revoke this privilege in writing. I understand that these records may include psychological information.

In consideration of this consent, I hereby release the above parties from any liability resulting from the release of this information.

_____ _____
Client Signature (or Guardian if a minor) **Date**

_____ _____
Client Name (Printed) **Witness Signature**

PHOTOCOPY OF THIS RELEASE/SIGNATURE IS AS VALID AS THE ORIGINAL SIGNATURE