PATRICIA GIBBERMAN, LCSW, BCD
Board Certified Diplomate in Clinical Social Work
Certified Gottman Couples Therapist
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Consent to Release Information

I, _____, give permission to Patricia H. Gibberman, LCSW, to exchange information regarding my psychosocial evaluation, treatment history, medical history, and any other pertinent information for the purpose of coordinating services with

_____

for the period of time from _____ to _____. This consent can be revoked in writing at any time.

Signed: _____

Date: _____

Witnessed By: _____