320 W. Lanier Ave., Suite 200, Fayetteville, GA 30214 • Tel 404.566.5402

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I, ____, do hereby authorize Dr. Tiffanie Davis Henry to release to and/or exchange my medical information with:

Person or agency:____

Address:____

Information Released/Requested:

- **( ) Summary of findings, treatment or recommendations**
- **( ) Progress Notes**
- **( ) Psychiatric Evaluation**
- **( ) Other**
- **( ) Laboratory Reports**
- **( ) HIV/AIDS Info**
- **( ) Substance Abuse Info**
- **( ) Open lines of communication**

(Specify):____

This information will be used for the purpose:

- **( ) Planning and coordinating treatment**
- **( ) Reimbursement for treatment**
- **( ) Legal reasons**
- **( ) Other (Specify): ____________**

I understand that all information I hereby authorize to release/obtain will be held strictly confidential and cannot be released/obtained without my written consent.

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time by giving written notice to Tiffanie L. Davis Henry, PhD, MA, LPC

If no prior notice of revocation is received, this consent will expire automatically two (2) years after the date indicated thereon.

____ ____________________

Patient Signature **Date**

DOB:_______________ SS#_______________________

____ ____________________

Guardian/Parent Signature **Date**