Joanne M. Pulley, MS, LPC, NBCC

6100 Lake Forrest Drive, Suite 450

Atlanta, GA 30328

404-242-5612

Consent and Authorization to Release Information:

To authorize: (name)

_____

(address) _____

_____

(Phone) _____(Fax) _____

To Release to: (name)

_____

(address)

_____

_____

(Phone) _____(Fax) _____

The following information: (check appropriate request)

( ) Psychiatric Data Base ( ) Psychiatric Evaluation

( ) History and Physical Exam ( ) Progress Notes

( ) Laboratory Reports ( ) Admission History

( ) Psychological Evaluation ( ) Social History

( ) Consultations ( ) Other (specify) _____

Contained in the record of/ concerning:

Patient Name: _____Date of Birth_____

The information is needed for the purpose of: ( ) Continued Treatment_____ ( ) Other:_____

I understand that these records may include psychiatric, drug/alcohol, and/or HIV III testing results and/or AIDS related information.

Client Signature: _____Date Signed: _____

Parent or legal guardian signature: _____ Witness _____