Chip Abernathy, LPC
6100 Lake Forrest DR, Suite 450, Atlanta, GA 30328
Telephone (770) 862-7585

RELEASE OF INFORMATION TO PERSONS IN SUPPORT SYSTEM

I, (Please print name clearly) ____,
Date of Birth_____________, authorize Chip Abernathy, LPC to communicate by telephone, text, email, letter or in person with:

NAME:	RELATIONSHIP:	TELEPHONE NO.:
______________________________	____________________	__________________
______________________________	____________________	__________________
______________________________	____________________	__________________
______________________________	____________________	__________________

I authorize any of the following information to be released/obtained: My participation in counseling/psychotherapy; obtaining of information pertinent to my care; scheduling of appointments; education about treatment expectations or discharge options; contact in case of emergency or clinical concern.

The purpose of this communication is to: Advise the above-named individual(s) of my involvement and/or progress in counseling/psychotherapy; obtain information; schedule appointments; educate the above-named individual(s) about treatment expectations or discharge options; contact in case of emergency or clinical concern

I understand that I may revoke this authorization at any time except to the extent that action has already been taken. It remains valid from the date of my signature unless I specify a termination date here: _________

____ ___________________
Patient signature Date

____ ___________________
Parent or guardian signature (if applicable) Date

____ ___________________
Witness signature Date

PROHIBITION OF REDISCLOSURE: THIS INFORMATION MAY BE PROTECTED BY FEDERAL REGULATION (42 CFR PART 2), WHICH PROHIBITS FURTHER DISCLOSURE.