Kimberly Wallace, LPC LLC

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AUTHORIZATION TO RELEASE INFORMATION

l,	, born on _	hereby	authorize Kimberly Wall	ace, LPC
	(client) or disclose my protected health inform			
Name/Organization		Relation	Relationship	
Addres	ss			
Phone		Fax		
	purpose of: (check all that apply) Further mental health evaluation, treatment planning Other:			
Items t	ation to be released: For release indicated by an x in the boxe h them. Page numbers indicated when questor:			
<u> </u>	Intake and discharge summaries Treatment summary		Medical record; history a Psychological Evaluation	
 I understand that this authorization will expire one year from my last date of service visit. A photocopy of this form will be considered as valid as the original. I understand that I may revoke this authorization at any time by Kimberly Wallace LPC LLC in writing to 2852 Johnson Ferry Road, Suite 101, Marietta, Georgia 30062, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand and agree to the above statements, items to be released and acknowledge understanding of the advantages and disadvantages of releasing this information. 				
If this i	orm is not signed in front of Kimberly V	Vallace LPC LLC staff, i	t must be notarized.	
Signatu	re of Client	Print Name		Date
Signature of Parent/Legal Guardian/Authorized Person		rson Prir	nt Name	Date
Relation	ship to Client			
Signature of Witness		Print Name	Date	

Notice to party receiving information. This information has been disclosed to you from records whose confidentiality is protected by Federal Laws which prohibit you from making any further disclosure of information without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations.