CONSENT FOR RELEASE OF INFORMATION

I authorize: *Sharon R. Peterson, LCSW, CEDS*
333 Sandy Springs Circle, Suite 127
Atlanta, GA 30328
404-330-4336

In regard to: (Name) _____ (DOB) _____
(Address) _____

To release the following, written/email or verbal conversation, from my records:
(specify information) _____.

To release/receive/exchange information with: (Name) _____
(Address & Phone) _____.

Relationship to client: _____.

This information may be given (frequency): _____ for the purpose of coordination of treatment through the following date: _____.

I understand that:

- **I may inspect or copy the protected health information to be used or disclosed.**
- **I may revoke this authorization in writing by contacting your office at the address below.**
- **Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPPA.**
- **I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).**

____ If checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Signature of Patient or Guardian: _____ Date: _____

Witness: _____ Date: _____