Owner:
Holly Johnson, LCSW
(706)207-7863

Email: holly@pathwayscounselingathens.com

c/o Pathways
1041 Oconee Forest Lane
Watkinsville, GA. 30677

Consent for Release of Information:

Name:_____ Date of Birth:_____

Address:_____

City/State/Zip:_____

I hereby authorize release of information so stipulated below.

Provider: Holly Johnson, LCSW

Recipient:_____Title:_____

Mailing Address:_____

City/State/Zip:_____

_____If **reciprocal, check here and fill out below:**

Provider: _____

Recipient:_____Title:_____

Mailing Address:_____

City/State/Zip:_____

**Information I want Released:

_____Dates of Service _____Number of Sessions

_____Symptoms _____Diagnosis

_____Progress Summary _____Progress Summary from _____to_____

_____Other, please specify_____

**Release information for the purpose of:

**Information to be released via:

_____ Face – to – face _____Phone _____Mail

Information released is strictly confidential and is accepted for use solely by and for the parties, as stipulated above for the purpose stated in this authorization. I understand that I have the right to inspect and copy the information released. I further understand that I have the right to revoke this consent in writing at any time. (Any revocation shall be in writing, signed by me and the signature witnessed by a person who can attest to my identity. No revocation of consent shall be effective until it is received by the person otherwise authorized to disclose records and shall have no effect on disclosures made prior thereto). I now authorize this release and stipulate **upon release this authorization expires unless otherwise noted**: _____ expires 2 weeks from now/ _____expires upon termination of treatment, or one year whichever comes first. This information cannot be re-released by recipient without my expressed, written consent, unless determined by state/federal regulations and/or HIPAA regulations, AND except to which action has already taken place in good faith, as requested herein.

_____Date_____
Client Signature

_____Date_____
Holly Johnson, LCSW

_____Date_____
Reciprocal Signature, if needed

Please sign and mail completed form to:

Holly Johnson, LCSW
c/o Pathways
1041 Oconee Forest Lane
Watkinsville, GA 30677