Kay Atchison, LCSW, ACSW

2301 Stonehenge Drive, Suite 202
Raleigh, NC 27615
P: 919.846.3455 F: 919.846.7748

AUTHORIZATION FOR RELEASE OF INFORMATION/RECORDS

Patient/Client: ______________________________ DOB: ____________

I, ____________________________________, give Kay Atchison, LCSW permission to

disclose information and/or obtain information from (medical doctor, psychologist, therapist, family member(s), attorney, school representative, hospital medical records, social security administration):

____

____

I authorize the following information to be released:

Clinical assessment and treatment progress

This consent may be revoked at any time with a written request. If not revoked, this consent will expire on _____________________.

____ ____________________
Patient/Client/Authorized/Representative Signature Date

____
Witness Signature