Amy S. Robbins LPC, RPT-S
109 Anderson Street #101, Marietta, GA 30060
Phone: 706-406-3404
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AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Client or Guardian :_____
Minor Child's Name: _____
Client birth date(s) : _____

I HEREBY REQUEST AND AUTHORIZE:
Name Amy Robbins LPC, RPT-S
Email: amyrobbinslpc@gmail.com
Phone: (706) 406-3404
Fax: (404) 591-7974
TO: ____ OBTAIN RECORDS FROM AND/OR _____RELEASE RECORDS TO:
Name/ Agency _____
Address: _____
_____
Phone: _____
To disclose the following specific information:
___ Psychiatric Evaluation ___ Psychological Reports ___ Medical Records
___ Psychosocial History ___ Treatment Plan ___ Labs (incl. Drug screen)
___ Case Records/Reports ___ Other _____

FOR THE PURPOSE OF:
_____
All information I hereby authorize to be obtained from this individual/agency will be held strictly confidential and cannot be released by the recipient without prior consent. I understand that unless otherwise limited by state or federal regulations and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. If not previously revoked, this consent will terminate one year from the date appearing below.

_____ _____
Client/Legal Guardian Signature Date

_____ _____
Amy S Robbins LPC Date

Date Consent Revoked: _____ Signature:_____