Sherri H. Rawsthorn, LCSW, CCE

265 W. Pike Street, Suite 4
Lawrenceville, Georgia 30046
(678) 377-6992

AUTHORIZATION TO RELEASE INFORMATION

Patient Name: ____

Date of Birth: ____

I hereby request and authorize Sherri Rawsthorn, LCSW to release, either in verbal or written form, the following information:

- ❑ Mental health records (including counseling/psychotherapy information, diagnosis, presenting problems, treatment details and treatment recommendations)
- ❑ Psychological evaluation and testing information
- ❑ Substance use evaluation and treatment records or
- ❑ Educational records
- ❑ Other (specify): ____

For the purpose of:

- ❑ Professional consultation
- ❑ Coordination of services
- ❑ Forensic evaluation
- ❑ Other (specify): ____

Other: ____

To / From: ____
____
____
Email: ____
Phone #: ____

- ❑ I also authorize the above-named party to release (either in verbal or written form) records, evaluations, opinions or other relevant information to Sherri H. Rawsthorn, LCSW.

All released information will be held strictly confidential and can not be further disclosed by recipient without expressed written permission. I may revoke this consent to release information at any time, unless otherwise limited by state or federal regulation. This consent will automatically expire one year from the date initiated.

____ _________________________
Signature of Client Date

____ _________________________
Signature of Parent / Guardian (if client is under age 18) Date