Patient Release of Information Authorization Form

A Journey to Peace LLC

3915 Harrison Rd SW

Suite 300

Loganville, GA. 30052

248-444-8132

Name:_____ DOB:_____

Address:_____ Phone:_____

I, _____, hereby authorize, A Journey to Peace LLC to disclose/exchange my mental health information and records obtained in the course of psychotherapy treatment, including but not limited to mental health diagnosis of the client listed above to:

Name:_____

Name of Company:_____

Address:_____

Phone:_____ Fax:_____

Date of Authorization:_____

Date of Expiration of Authorization:_____

Information to be released:

____ Psychotherapy Notes

____ Psychiatric Diagnosis (es)

____ Dates of Treatment

____ Entire Record

____ Other:_____

I understand that the release is valid for the dates stated above unless otherwise revoked in writing. I understand I may revoke this authorization at any time in writing. I, _____, hereby release the above parties from any legal liability resulting from the release of this information.

Client Name (Printed):_____

Client Signature:_____ Date:_____

Therapist Signature:_____ Date:_____