Candace Dale Mckenzie Counseling, LLC
4880 Lower Roswell Rd Ste 165 Unit 143 Marietta GA 30068
cdmcounseling@gmail.com
404 620 1540

AUTHORIZATION TO EXCHANGE/DISCLOSE INFORMATION

I, ___________________________, (Client Name) give my authorization to permit **Candace Mckenzie** , LMFT 001408, to request and exchange confidential, professional information with the following health practitioner, insurance company, or person.

Name:____
Address:____
Phone: _____________________________ FAX: ___________________

Information to be used/disclosed includes either, all health information pertaining to my medical history, mental or physical condition and treatment received _____ (Initial)

OR

Only the following records or types of health information (including any dates):
____

____

This protected health information is being used or disclosed for the following purposes:

For collaboration and to assist in treatment plan.

This authorization will expire **3 months following treatment termination**.

I have the right to revoke this authorization in writing except to the extent that my therapist has acted in reliance upon this authorization. My written revocation must be submitted to Candace Dale Mckenzie Counseling at the above address. In consideration of this consent, I hereby release **Candace Mckenzie**, LMFT, and the above named parties from any and all liability arising there from.

Client:

____
Signature Date

Therapist:

____
Signature Date