



138 Washington St.
Jefferson, GA 30549
(706) 387-0573 Fax (706) 387-0573

CONSENT FORM FOR EXCHANGE/RELEASE OF INFORMATION

CLIENT NAME: _____

DATE OF BIRTH: _____ SSN: _____

LEGAL GUARDIAN IF PATIENT IS A MINOR: _____

I, _____, give my permission to Christine Dalton, LCSW, her staff and the person (s) listed below to exchange information and/or records regarding myself or my dependents. I give permission for a faxed or photocopied signature to serve as an original regarding this release. The purpose of this release is to share/release information for the benefit of the patient's diagnosis, treatment planning, continuity of care, family medical leave, disability requests and/or benefit claims for life/health insurance application. The information released pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the privacy act. This authorization may be subject to revoke by the individual signing this consent by providing a written, signed and dated request to withdraw the authorization except to the extent that action has already been taken.

1. _____

2. _____

3. _____

4. _____

Signature of Client

Date signed

Signature of parent/ guardian
(When applicable)

Witness