

**THE CENTER FOR MINDFUL EXPLORATION  
SUSAN MARSHALL, LPC, CPCS  
1111 Mooty Bridge Road, Ste A / PO BOX 800154  
LAGRANGE, GA 30240  
706-333-2879**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I, \_\_\_\_\_, give full authorization to Susan Marshall, LPC to provide/exchange information regarding my mental health information to/with:

\_\_\_\_\_  
Name of Insurance Provider

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Insurance ID #

\_\_\_\_\_  
Group #

\_\_\_\_\_  
Name of Insured

\_\_\_\_\_  
Insured's SSN

for the purpose(s) of: Billing

I understand that authorization shall remain valid from the date of my signature below and ending one year from the date this authorization is signed.

I have been informed that I may revoke this authorization by written communication to Susan Marshall, LPC at any time.

I certify that this form has been fully explained to me and that I understand its contents.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date of Authorization