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 PRIMARY CARE PHYSICIAN (REQUIRED BY INSURANCE)

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

_____
Name (Primary Care Provider)

_____
Phone Number

_____
Street Address

_____
City, State, Zip Code

for the purpose(s) of:

coordination of care

_____
_____

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