THE CENTER FOR MINDFUL EXPLORATION
1111 Mooty Bridge Road Ste A/ PO BOX 800154
LAGRANGE, GA 30240

AUTHORIZATION FOR RELEASE OF INFORMATION EMERGENCY CONTACT/ OTHER

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

_____ Relationship: _____
Name

_____
Phone Number

_____
Street Address

_____
City, State, Zip Code

Or

____I DO NOT want any information released to my significant others, but I realize if my safety is at risk this desire may not be applicable.

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 or Legal Guardian Date of Authorization