***CONSENT TO RELEASE INFORMATION***
*Logan K. Williamson, LPC, LLC*

In regard to the records of:

Name: _____
DOB: _____ SSN: _____

I _____, consent that Logan K. Williamson, LPC may:

___ Exchange ___ Provide ___ Receive

The following information about treatment:

___ Treatment summary or progress ___ Diagnosis
___ Attendance ___ Other: _____

With the following person(s) or entities:

_____

| | |
|---|---|
| Name/Agency: | Name/Agency: |
| Address: | Address: |
| City: | City: |
| State: | State: |
| Zip: | Zip: |
| Telephone: | Telephone: |
| Fax: | Fax: |

For the purpose of: ___ Continuation of Care ___ Education Planning ___ Legal

Other: _____

I fully understand this authorization to release information and request to release or obtain records and information from my records at the nature of the records, their contents, the

consequences and implications of its release, and my request is wholly voluntary on my part. I

hereby release the source of these records from any liability arising from their release. I authorize the parties above to talk by telephone about my referral, diagnosis, treatment, and similar topics relevant to the above listed purpose for this release of records. I understand the provision of services is not contingent upon this releasing of information.

This “consent to release information” form is valid for one year, or as allowed by state law. I understand that I may revoke this consent at any time in writing except to the extent that action based on this consent has been taken.

_____

Print Name Date

_____

Signature

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