

Anne Ethier, LPC  
(706) 614-6060

Email: [anne@pathwayscounselingathens.com](mailto:anne@pathwayscounselingathens.com)

Pathways  
Inc.

Pathways, Inc.  
c/o 150 Curtis Way  
Athens, GA. 30605



**Consent for Release of Information:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

*I hereby authorize release of information so stipulated below.*

*Provider: Anne C. H. Ethier, LPC*

Recipient: \_\_\_\_\_ Title: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

\_\_\_\_\_ **If reciprocal, check here and fill out below:**

**Provider:** \_\_\_\_\_

Recipient: \_\_\_\_\_ Title: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

**\*\*Information I want Released:**

\_\_\_\_\_ Dates of Service \_\_\_\_\_ Number of Sessions

\_\_\_\_\_ Symptoms \_\_\_\_\_ Diagnosis

\_\_\_\_\_ Progress Summary \_\_\_\_\_ Progress Summary from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ Other, please specify \_\_\_\_\_

\*\*Release information for the purpose of:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*\*Information to be released via:

\_\_\_\_\_ Face – to – face \_\_\_\_\_ Phone \_\_\_\_\_ Mail

Information released is strictly confidential and is accepted for use solely by and for the parties, as stipulated above for the purpose stated in this authorization. I understand that I have the right to inspect and copy the information released. I further understand that I have the right to revoke this consent in writing at any time. (Any revocation shall be in writing, signed by me and the signature witnessed by a person who can attest to my identity. No revocation of consent shall be effective until it is received by the person otherwise authorized to disclose records and shall have no effect on disclosures made prior thereto). I now authorize this release and stipulate **upon release this authorization expires unless otherwise noted:** \_\_\_\_\_ expires 2 weeks from now/ \_\_\_\_\_ expires upon termination of treatment, or one year whichever comes first. This information cannot be re-released by recipient without my expressed, written consent, unless determined by state/federal regulations and/or HIPAA regulations, AND except to which action has already taken place in good faith, as requested herein.

\_\_\_\_\_  
Client Signature Date \_\_\_\_\_

\_\_\_\_\_  
Anne Ethier Date \_\_\_\_\_

\_\_\_\_\_  
Reciprocal Signature, if needed Date \_\_\_\_\_

Please sign and mail completed form to:

Anne Ethier  
c/o Pathways  
150 Curtis Way  
Athens, GA 30605