



Stephanie L. Furness, LCSW
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Consent for Release of Information:

Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

I hereby authorize release of information so stipulated below.

Provider: Stephanie L. Furness, LCSW

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 _____

Stephanie L. Furness, LCSW Date _____

Reciprocal Signature, if needed Date _____

Please sign and mail completed form to:

Stephanie L. Furness, LCSW
C/o Pathways
985 Gaines School Road
Bldg. #2, Office A
Athens, GA 30605