# Annie M. Garry, LCSW

**3050 S. Atlanta Road**
**Smyrna, GA 30080**
**Telephone: (770)598-0496**
**Fax: (770)436-8323**


## AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____

Social Security Number: _____ Date of Birth: _____

I hereby request and authorize the following information to be released to / from Annie M. Garry, LCSW:

- ❑ My mental health records in its entirety; or
- ❑ My substance evaluation / treatment record in its entirety; or
- ❑ Other (specify): _____

For the purpose of:

_____

_____

To / From: _____

_____

_____

Fax #: _____

Phone #: _____

- ❑ I also authorize two-way verbal or written communication between the Annie M. Garry, L.C.S.W., P.C. and the above named party.

All released information will be held strictly confidential and can not be further disclosed by recipient without expressed written permission. I may revoke this consent to release information at any time, unless otherwise limited by state or federal regulation. This consent will automatically expire one year from the date initiated.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent / Guardian (if client is under age 18) Date

_____ _____
Signature of Witness Date