Rachel Krasner, LMSW
171 Village Parkway NE, Building 8A
Marietta, GA 30067
404-520-1762

AUTHORIZATION TO RELEASE INFORMATION

Client Name: _____

Birth Date: _____

I REQUEST AND AUTHORIZE Rachel Krasner, LMSW TO:

_____ Release To: _____ Request From:

_____
(Name)

_____
(Address)

_____
(City/State/Zip Code)

(PHONE) _____ (EMAIL) _____

Information released may include mental health privileged or confidential information, alcohol, drug or other treatment information. Certain communications are privileged and not subject to release without your consent under state and/or federal law.

After considering the above statement, I authorize Rachel Krasner, LMSW to furnish information regarding my treatment to the above person or organization. I also agree to hold harmless Rachel Krasner, LMSW from all liability that may arise from the release of information requested.

I understand that this authorization may be revoked by me at any time, except when information released in accordance with state or federal law.

_____ _____ _____
Date Signed Client Signature Parent Signature/Legal Guardian