Angie Heath, LCSW
Clinical Conversations, Inc

5680 Peachtree Pkwy, Ste B
Peachtree Corners, GA 30092
470.299.1379

Consent Release Confidential Information

I,_________________________________ , hereby authorize an exchange of confidential medical information between the following persons or agencies:

1. Angie L. Heath, LCSW	2. ___________________________
Clinical Conversations, Inc.	______________________________
5680 Peachtree Parkway, Suite B	______________________________
Peachtree Corners, GA 30092	______________________________
Fax: (470) 375-7727	______________________________

The following items may be copied and/or provided:

( ) Treatment Attendance
( ) Level of Participation
( ) Treatment Plan
( ) Discharge Summary
( ) History and Physical Exam
( ) Progress Notes
( ) Psychiatric Reports
( ) Psychological Reports
( ) Medical Reports
( ) Diagnosis
( ) Testing Results
( ) Verbal Communications
( ) Other ____

The disclosure of information is required for the following purpose(s):

( ) Coordination of Treatment
( ) Other:____

I understand that this consent is revocable, in writing, at any time prior to its expiration which will occur on _________________________________.

_________________________________ Client's Signature	___________________________________ Date
_________________________________ Parent/Legal Guardian or Partner Signature	___________________________________ Date
_________________________________ Clinician's Signature	___________________________________ Date