Intimate Details, LLC
Individual, Couples & Sex Therapy
34 Lenox Pointe, NE, Atlanta, GA 30324 • Tel 4048638932 • Fax 4042640743

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I, _____, do hereby authorize Dr. Tiffanie Davis Henry to release to and/or exchange my medical information with:

Person or agency:_____

Address:_____

Information Released/Requested:

( ) Summary of findings, treatment or recommendations
( ) Progress Notes
( ) Psychiatric Evaluation
( ) Other
( ) Laboratory Reports
( ) HIV/AIDS Info
( ) Substance Abuse Info
( ) Open lines of communication

(Specify):_____

This information will be used for the purpose:

( ) Planning and coordinating treatment
( ) Legal reasons
( ) Reimbursement for treatment
( ) Other

(Specify): _____

I understand that all information I hereby authorize to release/obtain will be held strictly confidential and cannot be released/obtained without my written consent.

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time by giving written notice to Tiffanie L. Davis Henry, PhD, MA, LPC

If no prior notice of revocation is received, this consent will expire automatically two (2) years after the date indicated thereon.

_____ _____
Patient Signature **Date**
DOB:_____ **SS#**_____

_____ _____
Guardian/Parent Signature **Date**