CHRIS GARRISON ARCHER, LSCSW

Licensed Clinical Specialist Psychotherapist

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Release of Information

This authorizes Chris Garrison Archer, LSCSW, to disclose information to and receive information from:

_____

(Specify name of person or organization)

Information to be released:

_____ History
_____ Diagnosis
_____ Summary of Treatment
_____ Medical Care
_____ Other _____

This consent is valid for nine (9) months from the date of signing or until revoked. The revocation will not affect any action taken prior to the date of revocation. You are advised that at any time between the time of signing and the expiration date, you have the right to revoke this consent.

_____

Client's Name Date of Birth

_____

Client's Signature Date

or

_____

Responsible Party's Name

_____

Signature of Responsible Party Date