Lisa Tallant, Psy.D., LLC
2310 Peachford Road, Suite 200
Dunwoody, GA 30338 (404) 578-6543

Consent for Release of Information

Patient's Name _____Date of Birth_____

To the patient: I am conscientious about maintaining confidentiality while coordinating your care with other healthcare professionals as needed. Please list any physicians, psychiatrist, or mental health therapist you have seen in the last two years. Please list any family members with whom you think I may need to contact.

Professionals	City	State	Phone Number	Reason

Family Members	Phone Number	Relationship

Specific information to be released or received: The information exchanged with other health care professionals could be diagnoses, treatment plans, recommendations for cu treatment, a statement of progress in treatment, or names of other care providers.

I here by request and/or consent for Lisa Tallant, Psy.D. to release and obtain the above information regarding my dependent or myself. I understand this information may include information and records protected under Federal Law (such as alcohol and drug use treatment information) and/or protected under State Law (such as mental health treatment, privileged communications, communicable or infectious diseases, alcohol and drug use, AIDS or HIV) I also understand I many cancel this consent at any time in writing. The revocation will not be effective in regards to any action Lisa Tallant, Psy.D. has taken in reliance on the consent. This authorization will automatically expire six months after my termination of services.

The following are clinicians I have seen in the past two years or family members whom I do not give consent for you to contact.

Name/Relationship

_____

_____

_____ Date _____

Patient/or Guardian Signature

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