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TWO WAY RELEASE OF INFORMATION FORM

Client's name:____

I authorize:____

To disclose to: **Dr. Elizabeth Anderson**
Life Transformation Psychological Center, P.C.
1755 N. Brown Rd., Suite 200
Lawrenceville, GA 30043
770-674-8257

The following type of information:

____
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This release is in effect for six months, unless otherwise specified here:______________________

I also authorize: **Dr. Elizabeth Anderson and Life Transformation Psychological Center, P.C.**

To disclose to:

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Information obtained during the course of my assessment/treatment. Such disclosure shall be limited to the following type of information:

____
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This release is in effect for six months, unless otherwise specified here:______________________

Signature:____ Date:__________________________

Witness:____ Date:__________________________