5000 Research Court, Suite 725 Suwanee, Georgia 30024
770.883.9728 www.ElizabethCookeCounselor.com

CONSENT TO EXCHANGE CONFIDENTIAL INFORMATION

I, _____ hereby authorize the exchange of confidential medical information regarding _____ DOB: _____ between/among the following persons/organizations/agencies:

1. Elizabeth M. Cooke, M.S., LPC, NCC	2.	3.
5000 Research Court		
Suite 725		
Suwanee, Georgia 30024		
770.883.9728 fax 678.584.5699		
elizabeth@ ElizabethCookeCounselor.com		

The following items may be copied and/or provided:

(X) Treatment Attendance
(X) Discharge Summary
(X) Psychiatric Reports
(X) Laboratory Reports
(X) Educational Reports
(X) Legal Documents/Information
(X) Alcohol/Drug Information
(X) Level of Participation
(X) History and Physical Exam
(X) Psychological Reports
(X) Medical Reports
(X) Disciplinary Reports
(X) Diagnosis
( ) Other _____
(X) Treatment Plan
(X) Progress Notes
(X) Consultation Notes
(X) Testing Results
(X) Verbal Communications
(X) Electronic Comms.

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

(X) Coordination of Treatment and Psychotherapeutic Services

(X) Referral to/from listed entities

( ) Other: _____

I understand that this consent is revocable, in writing, at any time prior to its expiration, which will occur on _____ or one year from today, whichever is later.

_____ _____
Patient's Signature Witness

_____ _____
For Minor: Parent/Legal Guardian Signature Date