# AUTHORIZATION AND RELEASE FORM

I, _____, do hereby authorize Dr. Malcolm E. Anderson, to communicate with _____ regarding information concerning my psychotherapeutic treatment.

To the extent authorized herein, I therefore, ***waive*** my right of confidentiality and privacy with respect to this information and wish it to remain in confidence with, and only with, Dr. Anderson and the above mentioned party. Further release of this information without my authorized consent is considered unlawful.

I have read this document carefully and understand its contents and terms and, furthermore, agree to the authorized disclosure of information mentioned to the above mentioned parties.

_____
Print Name

_____
Signature

_____
Date

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Dr. Malcolm E. Anderson
Licensed Psychologist
GA PSY002450