RELEASE OF INFORMATION FORM

Kristy Money, Ph.D. Licensed Psychotherapist
Athens, GA 30606

I,____, the undersigned, hereby authorize Dr. Kristy Money, to provide information to and receive information from (relevant to my psychological treatment) the following entity/entities:

Name:_________________________________Relationship _________________________

Address:____

Fax: (______)________-_______________ Phone Number (______)_______-____________

Name:__________________________________Relationship ________________________

Address:____

Fax: (______)________-_______________ Phone Number (______)_______-____________

Name:___________________________________Relationship ________________________

Address:____

Fax: (______)________-_______________ Phone Number (______)_______-____________

I acknowledge that the authorization is hereby granted voluntarily and that this release is valid for one year. I further understand that I may cancel or revoke this authorization at any time in writing.

Name (Last, First, Middle): ____

Address:____

Date of Birth (mm/dd/yy):______/______/______

Signature____________________________________Date: _________________________