Amy Watson, MS, LPC

_____ _____/____/_____
First Name Middle Initial Last Name Date of Birth

Authorize a Two way release of information between:

Name:_____ Amy Watson, MS, LPC

Address:_____ 2405-D Nash St. NW
Wilson, NC 27896

City/State/ Zip:_____ Office: (252)291-8909
Fax: (252) 291-9223

Please release the following medical information on the above mentioned patient.

( ) Information covered by this authorization:
_____
_____
_____

( ) Information obtained during the following time period: _____ _____
(from) (to)

This disclosure is being made for the following purpose(s): Please circle all that apply

- Continuity care
- Attorney/court case
- Transfer of care
- Insurance
- Workman's compensation
- Other. Please explain_____
  _____

I understand this authorization is effective through_____. I understand that I may revoke or terminate this authorization by submitting a written revocation to Amy Watson at 2405-D Nash St. NW, Wilson, NC 27896. I understand that the information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent and that the privacy of this information may not be protected under the federal privacy regulation.

_____
Signature of Patient Date

_____
Signature of Guardian Date

_____
Signature of / Witness Date