

Suzann Lawry, Ph.D.

Licensed Clinical Psychologist

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Consent to Receive Information

I agree for \_\_\_\_\_

located at \_\_\_\_\_

to release the following information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For the purpose of:

Continuity of Care,

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To: Dr. Suzann Lawry located at 2751 Buford Hwy Atlanta, GA 30324

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Suzann Lawry, Ph.D. (witness)

\_\_\_\_\_  
Dates Consent is Valid