Northeast Georgia Counseling
359 Peevy Street
Buford, Georgia 30518
770-271-5040
678-765-6931 Fax

AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____

Social Security Number: _____ Date of Birth: _____

I herby request and authorize the following information to be released to / from Northeast Georgia Counseling:

- o My mental health records in its entirely; or
- o My substance evaluation / treatment record in its entirely; or
- o Other (specify): _____

For the purpose of:

To / From: _____
_____
_____
Fax#: _____
Phone #: _____

- o I also authorize two-way verbal or written communication between Northeast Georgia Counseling and the above named party.

All released information will be held strictly confidential and cannot be further disclosed By recipient without expressed written permission. I may revoke this consent to release Information at any time, unless otherwise limited by state or federal regulation. This Consent will automatically expire one year from the date initiated.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent / Guardian (if client is under age 18) Date

_____ _____
Signature of Witness Date