Counseling Innovations
Behavioral Health & Wellness Center
130 Vann Street NE, Ste. 220 • Marietta, GA 30060

Authorization to Release or Obtain Information and Records

I, _____(Client Name),
authorize my therapist:_____ and
Counseling Innovations, LLC, to release/obtain records or communicate
_____ (Person/Organization)
_____ (Address)
_____(Phone/Fax)
Concerning (myself, my child, other) _____(Name).

I understand that under Georgia Law, communication between a client and his/her counselor is privileged and may not be disclosed by the counselor unless the client consents. I also understand that client records maintained by a counselor cannot be disclosed to a third party, except with the clients consent through the legal process. The only time the above is not in effect is when there is a threat of danger to self or others, or when required by law. I understand that this authorization allows for the discussion of my case with a colleague, or an appropriate state agency. I agree to pay a reasonable copy cost for written documents to be released.

This authorization shall remain in effect until revoked by client or parent/guardian in writing.

This _____ day of _____ 20_____.

_____
Signarure of client or parent/guardian of child/adolescent

_____
Witnessed By Date