Holy Family Counseling Center
1810 Peachtree Industrial Blvd. Ste. 120
Duluth, GA 30097
(678) 993-8494

REQUEST FOR RELEASE/EXCHANGE OF CLIENT INFORMATION

I, _____ HEREBY AUTHORIZE _____ to
(Requesting therapist)

Release/exchange information contained in my client records to the following individual(s)

and/or organization _____.
(Name and phone number of person to be contacted)

The type of information to be released might include records or information concerning attendance, treatment plan, clinical assessment, psychological history, goals and progress, prognosis, or other information pertinent to the successful treatment of said client. The purpose for such disclosure/exchange might include continuity of treatment, family involvement, community support, aftercare planning or referral.

I hereby release Holy Family Counseling Center,_____ from
(Requesting therapist)

any and all liabilities, responsibilities, damages and claims which might arise from the release of the information authorized above. I understand that information may be transmitted by electronic means such as by fax and/or email. Portions of the information provided may not pertain exclusively to my current diagnosis. I also understand that I may revoke this consent at any time or that is expires automatically as described below.

Date, Event, or Condition of Expiration:_____

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will:

_____ _____
Signature of Client Date Witness Date

_____ _____
Parent, Guardian, or Authorized Representative Relationship to Client Date