THE ATLANTA COUNSELING GROUP LLC

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name: _____ DOB: ___ - ___ - ___

I hereby authorize **The Atlanta Counseling Group LLC** (ACG) and my therapist to release, obtain, or exchange information about my mental health treatment, either verbally or in writing, to the following agency or individual:

Name: _____
Address: _____
Telephone: _____ Fax: _____

□ All records pertaining to my mental health evaluation and treatment

□ Other (please specify): _____
_____
_____

The purpose of this release is: _____
_____
_____

I acknowledge that this release may be revoked in writing at anytime, and that otherwise it is valid until termination of treatment. I hereby release my therapist at ACG as well as ACG from any and all liabilities, responsibilities, damages, claims, or legal actions that might arise from the release of the information authorized above. I also release my therapist at ACG as well as ACG from liability or responsibility for the disposition of these records once in the hands of the person or agency named above.

Signature of Client/Legal Guardian: _____ Date: _____

Signature of Client/Legal Guardian: _____ Date: _____

Witness (*if requested by client*): _____ Date: _____

Signature of ACG Therapist: _____ Date: _____

TO THE RECEPIENT OF THIS LEGALLY PROTECTED INFORMATION: This information is released specifically to you from records that are legally protected. You are prohibited from further releasing this information to any other party without specific written consent of the person to whom it pertains. The use and disclosure of information contained in this record is restricted by the Health Insurance Portability and Accountability Act of 1996 and is protected under the Privacy Act of 1974.