Atlanta Family
COUNSELING

190 Camden Hill Rd Ste A Lawrenceville, GA 30046
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www.atlantafamilycounselingcenter.com

NAME: ____ DOB____________________

I, the above mentioned, authorize Atlanta Family Counseling Center, Inc. to release/obtain information to the facilities/persons listed below by mode of: Fax, Phone, Personal Conference, or Copies, that may be needed to treat me more effectively.

To: Facility/Person____ Phone: __________________

Address: ____

____

Date of Service: __________________

Information to be sent:

___ Results of psychological testing
___ MMPI profile
___ Medication
___ Diagnosis
___ Statement of Progress
___ School records
___ Other
___ Discharge Summary
___ Recommendation for current therapy
___ Domestic Violence Orientation
___ Anger Management Evaluation
___ Substance Abuse Evaluation
___ Psychosocial Evaluation

To be used for the purpose of: ____

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"This information has been disclose to you from records whose confidentiality is protected by federal law. Federal regulation (42, CRF, Part II) prohibit you from making any further disclosures of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose."
This authorization to release/receive information shall be effective for twelve months. You may terminate this authorization, however, at any time except to the extent that the program or person making the disclosure has already acted in reliance upon it.

I hereby release Atlanta Family Counseling Center, Inc. from all legal liability that might arise from the release of information requested. I consider a photocopy of this authorization to be as valid as the original.

_________________________________ _________ _____________________________ ______
Client Date Parent/Legal Guardian (relationship) Date

_________________________________ _________
Witness Date