CARE & COUNSELING CENTER OF GEORGIA

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize: Care & Counseling Center of Georgia
Clinician:____
1814 Clairmont Road
Decatur, GA 30033
404-636-1457

To release to: Name____
Address____
Phone ____

I authorize: Name____
Address____
Phone____

To release to: Care & Counseling Center of Georgia
Clinician____
1814 Clairmont Road
Decatur, GA 30033

_____Diagnosis, Services Provided, Dates
_____Treatment Summary
_____Assessment Report
_____ Psychological Testing Information
_____ Medical History, Physical Exam
_____Other________________________

This information will be used for my evaluation, treatment, follow-up care, and/or determine benefits payable and claim insurance for treatment services.

I hereby release both of the above parties from any liability that may result from furnishing the information released. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that, in any event, this consent shall expire 90 days after completion of services provided by the Care & Counseling Center of Georgia.

Date:______________ Client Name:____________________________ DOB_______________

Witness:________________________ Client Signature_________________________________

Parent/Legal Guardian_____________________________

1/2006