A New Start Counseling Center, Inc.

115 Habersham Drive • Fayetteville, Georgia 30214 • Tel: (770) 461-9944 • Fax: (770) 461-9779

Authorization to release information

_____ _____

Name of the client (person receiving services at A New Start Counseling Center - ANSCC) *Date of Birth*

_____ _____

Name of the individual or organization who will provide information to the client's counselor at ANSCC *Name of the client's counselor at ANSCC*

I give permission for the above-named individual/organization to provide information concerning the above-named client to his/her counselor at A New Start Counseling Center, including (check all that apply):

☐ **prior history or background information**
☐ **observations of behavior or current concerns**
☐ **history of mental health treatment, including symptoms, diagnoses, interventions and response to treatment**
☐ **academic performance, school adjustment, and school-based services and interventions**
☐ **work history and performance**
☐ **other (please describe)_____**

This information may be disclosed through direct conversation and/or through provision of written summaries, copies of previous treatment records, copies of academic records, and copies of any assessments or evaluations. This release shall remain in effect (choose one):

☐ **for a one-time disclosure of information only**
☐ **until treatment with the client's ANSCC counselor has ended**
☐ **until a specific date: _____/_____/_____**

I understand that I have the right to revoke this authorization at any time by sending written notification to A New Start Counseling Center or the above-named individual/organization; although the revocation will not apply to any information already disclosed, it will prohibit further request for or disclosure of information.

☐ *Check here if you also want the client's ANSCC counselor to provide information to the individual/organization.*
I also give permission for the client's counselor at A New Start Counseling Center to provide clinical information to the above-named individual/organization. The purpose of this release is to provide necessary clinical background information and to allow for ongoing coordination of appropriate care and treatment interventions. I understand that it is my responsibility to discuss with the client's ANSCC counselor what information is to be released and how this will benefit the client.

☐ *Check here if you want the individual/organization to provide information to the client's ANSCC counselor, but do not want the client's ANSCC counselor to disclose information to the individual/organization.*

_____ _____ _____

Client's signature (or signature of the client's parent/ guardian if the client is a minor child) *Date* *Printed name of the parent/guardian who has signed on behalf of a minor client (if applicable)*

_____ _____

Witness signature *Date*