Authorization for Release of Information

Client Name: _____ Date of Birth: _____

I have been informed that under Georgia State Law and Federal Law, that all verbal, written and/or electronic communication between a client and Counselor is considered privileged information which may not be disclosed by the Counselor unless given consent by the client. Records maintained by the Counselor may contain alcohol and drug treatment information, client photographs, medical conditions and or psychiatric/psychological or other mental health privileged or confidential information. I have also been informed that client records maintained by a Counselor or other mental health or medical professional may not be disclosed to third parties except with the Client's consent or through legal process.

Therefore, I hereby request/authorize Michele McColligan, LPC of The Barden Group to obtain and/or release information to and from:

(Name of Source or Recipient of Information: _____

_____ _____ _____ _____
(Address) (City) (State) (Zip Code)

Telephone: _____ Fax: _____

The information will be used/disclosed for the following purpose(s):

_____ Background Information / Assessment
_____ Continuation of Care
_____ Other _____

I understand and agree that this Authorization will be valid and in effect until _____ /_____ /_____. I understand that after that date no more of this information can be used or released to the person or organization unless I sign a new Authorization.

I understand that I can revoke or cancel this Authorization at any time by submitting a letter to my therapist. If I do this, it will prevent any releases after the date it is received but cannot change the fact that information may have been sent or shared before that date.

I understand that my therapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to this Authorization may be subject to disclosure by the recipient of your information of which is not the responsibility of Glen Barden, LPC or The Barden Group and may no longer be protected by the HIPAA Privacy rule.

I agree to indemnify and hold harmless Amber Simons, LPC and The Barden Group's owner members, contractors and staff from all liability that may arise from the release of the information herein requested.

_____ _____
Client or Legal Guardian - Printed Name **Date**

_____ _____
Client or Legal Guardian - Signature **Date**