Authorization for Release of Information

Client Name: _____ Date of Birth: _____

I have been informed that under Georgia state law and Federal Law, that any and all verbal and or written 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 and authorize: ___ **Rene Howey, M.Ed., LPC** _____**,** of

The Barden Group to obtain and/or release information to and from:

_____

(Name of provider or agency)

_____

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

_____ _____

(Telephone Number) (Fax Number)

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

I understand that information to be obtained will be held strictly confidential and will not be released by the Barden Group without my written consent. Furthermore, I understand that this authorization is subject to revocation, in writing at any time, and is valid for a period of one (1) year from the date of my signature, unless I specify another date or event here: _____

_____ _____

Client or Legal Guardian Signature **Date**