

Ray of Hope Counseling Services, Inc.

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Kennesaw, GA 30144

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Suwanee, GA 30024

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Conyers, GA 30013
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AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION AND RECORDS

I, _____ (Your Name)
_____ (Address)

Authorize Ray of Hope Counseling Services to release/obtain records or communicate with: _____. Concerning (myself, child, other) _____ (Name)

I understand that under Georgia Law, communication between a client and his/her counselor is privileged and may not be disclosed by the counselor unless the client consents. I also understand that client records maintained by a counselor cannot be disclosed to a third party except with the clients consent through the legal process. The only time the above is not in effect is when there is threat of danger or what is required by law. This authorization also allows the discussion of my case with a colleague, or an appropriate state agency. I also agree to pay any reasonable copy cost. This authorization shall remain in effect until revoked by me in writing.

This _____ day of _____, 20__.

Signature of client or parent/guardian of minor child

Witnessed by

Date