

RAY OF HOPE COUNSELING SERVICES, INC

AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION AND RECORDS

I, _____ (YOUR NAME) authorize Ray of Hope Counseling Services to *release / obtain* records OR communicate with:

(name of organization or individual, phone, facsimile or email address)

Concerning: _____ (client name) _____ (DOB)

I understand that under Georgia Law communication between a client and his/her counselor is privileged and may not be disclosed unless the client consents. I also understand that client records maintained by a counselor cannot be disclosed to a third part except with the client's 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

Witness

Date

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5480 MCGINNIS VILLAGE PLACE, ALPHARETTA, GA 30005
1808 OVERLAKE DR., STE D, CONYERS GA 30013
1060 GAINES SCHOOL RD., STE B-3, ATHENS, GA 30605
203 OAKSIDE LANE, UNIT F CANTON, GA 30114
6000 SHAKERAG HILL, SUITE 308 PEACHTREE CITY, GA 30269
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