AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION AND RECORDS

I, _____ (YOUR NAME) authorize Ray of Hope Counseling Services to *RELEASE OR OBTAIN MEDICAL RECORDS OR TO* 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

4255 WADE GREEN RD, STE 414, KENNESAW GA 30144
5480 McGINNIS VILLAGE PLACE STE 104, ALPHARETTA, GA 30005
1808 OVERLAKE DR., STE D, CONYERS GA 30013
1060 GAINES SCHOOL RD., STE B-3, ATHENS, GA 30605
203 OAKSIDE LANE, STE F, CANTON, GA. 30114
6000 SHAKERAG HILL, STE 308, PEACHTREE CITY, GA. 30269
1000 JOHNSON FERRY RD., STE D 123, MARIETTA, GA. 30068
1838 OLD NORCROSS RD., STE 400, LAWRENCEVILLE, GA. 30044
1260 CONCORD RD. STE 203, SMYRNA, GA. 30080
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