Release of Information

Dr. Brenda Roberts, EdD, LPC, LMFT
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I, , hereby authorize Dr. Brenda Roberts, EdD, LPC, LMFT at New Horizons Counseling Center, L.L.C. to release information pertaining to my counseling sessions to:

(Name and address of primary care physician or others to whom information is to be released.)

for the purpose of:

(Indicate the specific reason.)

Information to be Released

No limitation, any information may be released to the party above.

Yes, limit the information released to:

No, I do not grant release to outside parties at this time.

I understand that authorization shall remain valid until it is revoked by the client.

I have been informed that I may revoke this authorization by written or oral communication to Dr. Brenda Roberts, EdD, LPC, LMFT at New Horizons Counseling Center, L.L.C. I certify that this form has been fully explained to me and that I understand its contents.

The parties agree that this document may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Client	Signature of Client	Date
Guardian	Signature of Guardian	Date
Witness	Signature of Witness	Date