614 Esplanade Street
Lake Charles, LA 70607
O (337) 478-1411 • F (337) 562-1489

Release of Information

I, ________________________________ , hereby authorize ***Brenda Roberts*** 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 ***Brenda Roberts*** 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.

____ ____________________________

Signature of Client Date of Authorization

____ ____________________________

Signature of Guardian Date of Authorization

____ ____________________________

Signature of Witness Date of Authorization

Client Name: ____