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

Release of Information

I, _____, hereby authorize **Linda Castle 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 **Linda Castle 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: _____