New Horizons
COUNSELING CENTER

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

Release of Information

I, _____ , hereby authorize ***Matthew McCauley*** 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 ***Matthew McCauley*** 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: _____