4Thought Counseling, LLC
11340 Lakefield Drive, Suite 200 Johns Creek, GA 30097
404.625.3031

Authorization to Release and Receive Confidential Information

Name of patient:_____ Date of birth: _____Social Security #: _____

I understand that the purpose of this release is to assist with my/this patient's treatment by improving communication between professional service providers or agencies and the important individual(s) in my/the patient's life. To further this goal, I authorize this specific service provider, therapist, case manager, or _____, to release and receive the below-specified information regarding me/the patient to the individual(s) listed below, and to receive information from them. I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

The information to be disclosed is marked by an X in the boxes below, and any items not to be released have a line drawn through them:

❑ Name of therapist ❑ Name of case manager ❑ Name(s) of treatment program(s)

❑ Admission/discharge information ❑ Treatment plan ❑ Scheduled appointments ❑ Progress notes

❑ Compliance with treatment ❑ Discharge plans ❑ Treatment summary

❑ Psychological evaluation ❑ Medications ❑ Other: _____

This information is to be disclosed to these persons, who have the indicated relationship to me/the patient:

_____ _____

Name of person

_____ _____

Name of person Relationship

_____ _____

Name of person Relationship

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire ❑ one year from this date, ❑ upon my discharge from treatment by this agency or by the person specified above, or ❑ under these circumstances: _____ .

_____ _____ _____

Signature of client Printed name Date

_____ _____ _____ _____

Signature of parent/guardian/representative Printed name Relationship Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____ _____ _____

Signature of witness Printed name Date

_____ _____ _____ _____

Signature of witness (a second witness is needed if person is unable to give oral consent) Printed name Relationship Date

❑ Copy for patient or parent/guardian ❑ Copy for provider/therapist/case manager ❑ Copy for family member