ANCHORED
COUNSELING SERVICES

67 Peachtree Park Dr NE Suite 102
Atlanta, Ga 30309
info@anchoredtherapy.life
(404) 282-1505

Authorization for Release of Information

_____ _____

Name of Client: Date of Birth:

I understand that Georgia law requires each client's consent for the release of confidential information related to mental health or developmental disability. With this understanding, I hereby waive any right to confidentiality arising under Georgia law and authorize the release of records of information, but only to the extent specified below. I authorize Anchored Counseling Services to release and/or receive the following information concerning myself or my child:

Diagnostic Evaluation Results	____	Treatment Summary	____
Educational Records	____	Discharge Reports	____
Progress Notes	____	Any and All Records	____
Treatment Plan	____	Other: _____	____

The above information is only to be released to, and/or from, the following party:

_____ _____

Name and/or Agency Address, City, State, Zip Code

This information is to be used for the purpose of _____.

This authorization shall remain in effect until _____ at which time it shall expire, and no further release of information shall be made under its terms. I understand that I can revoke this authorization at any time by giving written notice to the parties named above. I also understand that I have the right to examine and copy the information disclosed. I hereby release the parties named above from any liabilities for release of this information.

_____ _____

Signature of Client Date

If the Client is a minor:

_____ _____

Parent or Legal Guardian Signature Date