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 ***Brenda Roberts, EdD, LPC, LMFT*** 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, EdD, LPC, LMFT*** 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.

The parties agree that this agreement may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

_____ _____

Signature of Client | Date of Authorization (mm/dd/yyyy)

_____ _____

Signature of Guardian | Date of Authorization (mm/dd/yyyy)

_____ _____

Signature of Witness | Date of Authorization (mm/dd/yyyy)

Client Name: _____

Reset Form