



***New Horizons***  
*Counseling Center, L.L.C.*  
*614 Esplanade St.*  
*Lake Charles, LA 70607*



**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: Case consultation  
 (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

**337-478-1411**



**337-562-1489 (fax)**

Client Name: \_\_\_\_\_