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

RELEASE OF INFORMATION

I, _____, hereby authorize Linda Castle 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 revoked by the client.

I have been informed that I may revoke this authorization by written or oral communication to Linda Castle 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: _____