



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



RELEASE OF INFORMATION

I, _____, hereby authorize Kristen Paine 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 Kristen Paine 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: _____