Atlanta INNOVATIVE
COUNSELING CENTER

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name:_____
DOB:_____

I hereby authorize ***Atlanta Innovative Counseling Center, LLC (AICC) and my provider*** to **release, obtain, or exchange** information about my psychological/nutritional/medical treatment, either verbally or in writing, to the following agency or individual:

Name: _____
Address: _____
_____
Phone: _____ Fax: _____

AICC Location
_____ 4045 Orchard Road, Suite 110
Smyrna, GA 30080
Phone: 770-293-1950
Fax: 770-293-1955

____ All records pertaining to my psychological evaluation and treatment
____ Other _____

The purpose of this release is: _____

I acknowledge that this release may be revoked in writing at any time, and that otherwise it is valid until termination of treatment.

I hereby release my provider at AICC as well as AICC from any and all liabilities, responsibilities, damages, claims, or legal actions that might arise from the release of the information authorized above. I also release my provider at AICC as well as AICC from liability or responsibility for the disposition of these records once in the hands of the person or agency named above.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL
This information is released specifically to you from records that are legally protected. You are prohibited from further releasing this information to any other party without specific written consent of the person to whom it pertains. The use and disclosure of information contained in this record is restricted by the Health Insurance Portability and Accountability Act of 1996 and is protected under the Privacy Act of 1974.

_____ _____
Signature of Client/Legal Guardian Date

_____ _____
Signature of Client/Legal Guardian Date

As Witnessed By:

_____ _____
Signature of Provider Date