# Creative Family Counseling, LLC

**4330 South Lee St, Suite 600-A**
**Buford, GA 30518**
**Phone 770-648-2500**
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## Consent for Release of Client Information

**RE:** ______________________________________ (Client Name)
______________________________________ (Date of Birth)

I authorize ______________________________ with **Creative Family Counseling, LLC** to disclose to and/or obtain from:

Name_______________________________ Organization ________________________________________
Address_________________________________________________________________________________
________________________________________________________________________________________
Phone Number ____________________________ Fax Number _______________________________

**Description of Information to be Disclosed or Obtained:**

____ Reason for Referral
____ Summary of Evaluation and Treatment
____ Psychiatric, Psychological, Social, Medical and Family Information Affecting Current Functioning
____ Medication History and Current Medications
____ Alcohol and Drug History and Treatment
____ School Academic, Behavior, and Attendance Information
____ Progress Notes
____ Other
____ Reason for Terminating Treatment with _________________________________________

**Purpose**
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify:

________________________________________________________________________________________

I understand this information will be used only **to facilitate and coordinate delivery of services in the best interest of this client**. The doctrine of informed consent has been explained to me and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid for a period not to exceed one year. I further acknowledge that I may revoke this consent at any time, in writing, except to the extent that action based on this consent has been taken or information re-disclosed by the recipient and no longer protected by the HIPAA Privacy Rule.

__________________________________________ OR ______________________________________
Client Parent or Legal Guardian

__________________________________________ ______________________________________
Licensed Professional Counselor Date