Legacy Changers Counseling Centers
848 Hiram Acworth Highway, Suite 100, Terrace Level
Hiram, Georgia 30141
Phone: (404) 334-7575 FAX: 404-591-5453
www.LegacyChangersCounseling.com

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I _____ authorize the Legacy Changers Counseling Center to:

- ☐ release to:
- ☐ obtain from:
- ☐ exchange with:

_____

_____

_____

_____

the following information pertaining to myself:

- ☐ treatment summary
- ☐ history/intake
- ☐ diagnosis
- ☐ psychological test results
- ☐ psychiatric evaluation/medication history
- ☐ dates of treatment attendance
- ☐ progress notes
- ☐ discharge summary
- ☐ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event: _____ _____. (See back for authorization extension).

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ Social Security #:_____
Signature of Client Date OR
Date of Birth:_____

_____
Signature of Witness Date

(7/2018)

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RECORD OF AUTHORIZATION EXTENSIONS

I hereby confirm that I have reviewed this consent form and agree to its extension for an additional (check one):

- ☐ 6 months OR
- ☐ other (specify) _____

_____ _____
Client Date Witness Date

Check One:

_____ 6 months OR
_____ other (specify) _____

_____ _____
Client Date Witness Date

Check One:

_____ 6 months OR
_____ other (specify) _____

_____ _____
Client Date Witness Date