Authorization to Release or Obtain Information and Records

I, _____ (Client Name), authorize my therapist: *Kimberly Duff* and *Overcomers Counseling, LLC,* to release/obtain records or communicate with:

Person/Organization:_____

Address:_____

Phone/Fax: _____

Concerning (myself, my child, other) _____ (name).

I understand that under Georgia Law, communication between a client and his/her counselor is privileged and may not be disclosed by the counselor unless the client consents. I also understand that client records maintained by a counselor cannot be disclosed to a third party, except with the clients consent through the legal process. The only time the above is not in effect is when there is a threat of danger to self or others, or when required by law. I understand that this authorization allows for the discussion of my case with a colleague, or an appropriate state agency. I agree to pay a reasonable copy cost for written documents to be released.

This authorization shall remain in effect until revoked by client or parent/guardian in writing.

This ___ day of _____,2017.

_____

Signature of client or parent/guardian of child/adolescent

_____ _____

Witnessed By Date