**CURE COUNSELING & ASSESSMENT TRAINING CENTRE**

2594 Highway 34 East Suite #B Newnan, GA 30265

(770) 252-3760 Office Email: office@curecounseling.com

# **PERSONAL CLIENT**

# **RELEASE OF INFORMATION**

I,      , hereby authorize CURE COUNSELING & ASSESSMENT TRAINING CENTRE to release information pertaining to my evaluation and/or counseling sessions to:

for the purpose of:

**Additional Understanding**:

I understand that this authorization applies to any and all counseling sessions at CURE Counseling & Assessment Training Centre for past, present or future sessions. **I have been informed that I may revoke this authorization by written communication to CURE COUNSELING**. *I certify that I have been requested to read this form in its entirety and that I fully understand its content*. I further agree that I am aware and will abide by the Privacy Policies as set forth by CURE Counseling & Assessment Training Centre. In the unlikely event that a lawyer, judge, or court subpoenas my records, I am responsible, at my expense, to provide a Protective Order from the court to quash my subpoenaed records. If the Protective Order is not provided by the time the subpoenaed records are requested to be received, then I give my permission for CURE Counseling and/or counselors to use those records in the court of law or make them available to those who subpoenaed my records to be received, and will not hold CURE Counseling & Assessment Training Centre accountable for any HIPPA violation.

**Initials**

Signature of Client Date of Authorization & Full Agreement  
*I agree that all TYPED or electronic signatures are legally binding.*

Signature of Legal Guardian if client is under 18. Date  
*I agree that all TYPED or electronic signatures are legally binding.*

Signature of Witness Date  
*I agree that all TYPED or electronic signatures are legally binding.*