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AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ DOB: _____

I hereby authorize **Insights Psychological Center, LLC** to **release, obtain, or exchange** information about my psychological treatment, either verbally or in writing, to the following agency or individual:

Name: _____

Address: _____

Phone: _____ Fax: _____

Such information may include records of my psychological evaluation and treatment. This purpose of this release is:

_____.

I acknowledge that this release may be revoked in writing at any time, and that otherwise it is valid for sixty (60) days or until _____.

I hereby release **Insights Psychological Center, LLC** 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 **Insights Psychological Center, LLC** from liability or responsibility for the disposition of these records once in the hands of the person or agency named above and understand that the HIPAA Privacy Rule may no longer protect my information.

Signature of Client (or legal guardian)

Date

As Witnessed By:

Signature of Therapist

Date