



**THE POTTER'S WHEEL FAMILY COUNSELING**  
**Office: 770-386-0776**  
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**Authorization to Release Information**

Client Name: \_\_\_\_\_

Client Address: \_\_\_\_\_

Client Record #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

"I hereby authorize this practice to obtain and disclose my personal information as indicated below."

THIS INFORMATION IS TO BE DISCLOSED TO:

Name of entity: \_\_\_\_\_

Street address of entity: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Description of information to be disclosed: \_\_\_\_\_

To be read and signed by the client:

I understand the following:

1. I may revoke the authorization at any time by providing written notice to the practice
2. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
3. The practice will not decide treatment or payment based on my signing this authorization.
4. I am signing this authorization freely.
5. The information disclosed in this authorization may be subject to redisclosure by the recipient and is no longer protected by federal law.
6. I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.
7. I have received a copy of this authorization.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client's Representative: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_