RELEASE OF INFORMATION

Shala Nicely, LPC
Cornerstone Family Services, LLC
2993 Sandy Plains Road, Suite 110, Box 4
Marietta, GA 30066

Client's name _____ Date of Birth _____

I hereby request and authorize Shala Nicely, LPC to release to and request from (an individual, not an organization):

Name _____

Address _____

Phone _____

Fax and Email Address _____

The following information: □ Clinically-relevant information for coordination of care □ Treatment summary

□ Treatment plan □ Psychiatric evaluation/clinical assessment □ Laboratory reports □ Attendance

□ Other (please describe) _____

For the purpose of: □ Coordination of Treatment □ Other _____

Medical records frequently contain information which may be privileged and/or confidential. This could include remarks furnished by the client, client's family, or medical staff. If, in the judgment Shala Nicely, MS, disclosure of the privileged/confidential information will be harmful to the client, release of such information may be withheld in accordance with specific state and federal regulations. Records released may contain alcohol and drug treatment information, AIDS/HIV information, psychiatric/psychological/and other mental health privileged/confidential information. Certain communications are privileged and not subject to release without your consent under state and/or federal law. Please note that once information has been released to the designated party, neither Shala Nicely, LPC nor Cornerstone Family Services are liable for the misuse of information by that party.

After giving due consideration to the above statement, I authorize Shala Nicely, LPC to furnish/receive information, including faxed copies of my Protected Health Information, including matters privileged under the laws of the state of Georgia, and applicable federal laws and regulations, to the above person(s). I further agree to indemnify and hold harmless Shala Nicely, LPC, Nicely Done, LLC and Cornerstone Family Services from all liability that may arise from the release of the information herein requested.

I understand that this authorization is subject to revocation at any time *in writing* except to the extent that action has already been taken based on this authorization. This authorization is only valid for a period of 1 year from the date of my signature unless I re-sign and re-date below.

_____ _____

Client/ Parent/ Legal Guardian Signature Date