Authorization for Disclosure of Information

Patient Name: _____ Date of Birth _____

Address (including city/state/zip) _____
Phone Number: _____

**Release Information From:**

Provider/Facility Name:
_____
Address:
_____
City/State/Zip
_____
Phone:
_____

**Release Information To:**

Center for New Beginnings
P O Box 1066
727 West Sixth St.
Waynesboro, GA 30830

Phone: 706-437-0505
Fax: 706-554-6219
www.nbeginings.org

Information that may be used or disclosed through the Authorization is as follows:

- All educational and/or health information about me, including my clinical records
- All information about me, except _____
- Only specific information about _____

This Authorization is in effect for 12 months from the signature date: _____

I understand that I may revoke authorization at any time with a written signature.
I have read and understand the terms of this authorization. I have had an opportunity to ask questions about the use of disclosure.

All information received by the Center for New Beginnings will be used for services provided by the Center and will not be released to third parties.

Client Signature/Legal Guardian: _____
Print Full Name of Client: _____
Birth Date: _____ Date: _____

**Reaffirmation and Extension (if additional time is necessary to meet the purpose of this release)**
I confirm that this release is still valid, and I would like to extend the release until _____
New Date/Time
**Signed: _____Date: _____Witness:_____**