



**Supportive Solutions, LLC
Authorization for Contact**

This form allows Supportive Solutions, LLC Staff to verbally communicate with the Individual, Agency, Organization, or Company (including Insurance Company) that you identify below. The information exchanged will be on a need to know basis that focuses on supporting your counseling services and goals.

NAME : _____ **Date of Birth:** _____

Service Start Date: _____

Name/Address of Agency, Organization or Individual releasing/exchanging information : 	Name/Address of Agency, Organization or Individual to Whom Information is to be Released/exchanged: Supportive Solutions, LLC 5881 Glenridge Drive Suite 240 Atlanta, GA 30328 404-955-8167 phone 404-459-7172 fax www.supportivesolutionsga.com
Purpose of this release is: <input type="checkbox"/> Seeking other Healthcare <input type="checkbox"/> Educational Placement <input type="checkbox"/> Court Related <input type="checkbox"/> Vocational Services <input type="checkbox"/> Disability Determination <input type="checkbox"/> Aftercare Placements <input type="checkbox"/> Reimbursement <input type="checkbox"/> Continuity of Care <input type="checkbox"/> Transfer to other services <input type="checkbox"/> Aid in treatment planning <input type="checkbox"/> Discharge Planning <input type="checkbox"/> Family Support <input type="checkbox"/> Other- Please List:	

I am in full knowledge of informed consent and I understand the contact(s) are to be made pursuant to guidelines and regulations protecting the confidentiality of all parties involved. I hereby acknowledge that this authorization is truly voluntary. I further acknowledge that I may revoke this authorization at any time except to the extent that action based on this authorization has been taken.

CLIENT/PARENT/GUARDIAN _____ DATE _____

WITNESS _____ DATE _____