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:	Seeking other Healthcare	Educational Placement	Court Related
Vocational Services	Disability Determination	Aftercare Placements	Reimbursement
Continuity of Care	Transfer to other services	Aid in treatment planning	Discharge Planning
Family Support	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________________