THE SANDHURST CENTER
OUTCOME FOCUSED TREATMENT

AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION AND RECORDS

I, _____(Your Name)
authorize The Sandhurst Center, LLC to release/obtain records or communicate with:_____
concerning _____(Name: myself, child, other)

I understand that under North Carolina Law, communication between a client and his/her counselor is privileged and may not be disclosed by the counselor unless the client consents. I also understand that client records maintained by a counselor cannot be disclosed to a third party except with the client's consent through the legal process. The only time the above is not in effect is when there is threat of danger or what is required by law. This authorization also allows the discussion of my case with a colleague, or an appropriate state agency. I also agree to pay any reasonable cost. This authorization shall remain in effect until revoked by me in writing.

This _____day of _____, 20____.

_____
Signature of client or parent/guardian of minor child

_____
Witnessed by Date