Family Therapy Clinic

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Authorization to Release of Mental Health Information

I, ____, DOB__________________________,

authorize **Family Therapy Clinic of Louisiana, LLC** to disclose to and/or obtain from:

Name/Organization: ____
Address: ____
Phone Number: _______________________________ Fax Number:______________________________

Information to be released: □ All records *(except psychotherapy notes)*

□ Presenting complaint/issues
□ Diagnosis and/or assessment results
□ Treatment plan, goals, recommendations
□ Summary of treatment and prognosis
□ Substance/alcohol abuse information _______ *(initial)*
□ Attendance/scheduling/transportation
□ Information related to payment
□ Other____

Purpose: This information may be disclosed in connection with mental health treatment, payment, coordination of care, or healthcare operations.

Other Purpose *(specify)*:____

I understand that:

1) This authorization will automatically expire one year from signing unless a different date of expiration is specified here: ____
2) I have the right to copy and inspect the information being disclosed.
3) I have the right to revoke this authorization at any time by sending written notification to my provider's office, and that this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
4) Refusal to sign this authorization will not jeopardize my right to obtain present or future treatment except where disclosure of the information is necessary for treatment. However, it has been explained to me that failure to sign this authorization may have the following consequences: ________________________
____
5) Unless requested in writing that disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

____ ___________________________
Patient signature (Adult or Minor age 16 or older) Date

____ ___________________________
Parent/Guardian signature of minor or legally disabled patient Date

(NONE OF THE INFORMATION OR RECORDS OBTAINED UNDER THIS AUTHORIZATION MAY BE RE-RELEASED TO ANOTHER PARTY)