Family Therapy Clinic of Louisiana, LLC
8480 Bluebonnet Blvd, Suite A,
Baton Rouge, LA 70810-2879

Authorization to Release or Obtain Health Information

(Including written, verbal, and electronic information)

Patient Name * _____

Patient Address * _____

_____

_____

_____

Request Date _____

Patient Date of Birth * _____

Social Security # _____

AUTHORIZATION

******Unless otherwise instructed, please select both "RELEASE" and "OBTAIN"***

I authorize Family Therapy Clinic of Louisiana, LLC to (check all that apply): * ☐ RELEASE information to ☐ OBTAIN information from

Name & Relationship * _____

Mailing Address _____

City, State, Zipcode _____

Phone Number * _____

Fax Number _____

PURPOSE OF AUTHORIZATION

******Unless otherwise instructed, please select "MENTAL HEALTH EVALUATION AND/OR TREATMENT"***

The purpose of this authorization includes: *

- ☐ MENTAL HEALTH EVALUATION AND/OR TREATMENT
- ☐ Legal investigation or action
- ☐ Creating health information for disclosure to a third party
- ☐ Coordinating interdisciplinary treatment
- ☐ Changing physician
- ☐ Further medical care
- ☐ Research-related treatment
- ☐ Personal use
- ☐ Others _____

RECORDS TO BE RELEASED

******Unless otherwise instructed, please select "ENTIRE RECORD"***

I authorize the release of the following Protected Health Information (PHI): *

- ☐ ENTIRE RECORD
- ☐ Medical History
- ☐ Prescription
- ☐ Immunizations

- ☐ Hospital Records
- ☐ Radiology Reports
- ☐ Surgical Reports
- ☐ Laboratory Reports
- ☐ Genetic Testing Results*
- ☐ Mental Health Records*
- ☐ Voc-Rehab Records*
- ☐ HIV/AIDS Information*
- ☐ Sexually Transmitted Disease*
- ☐ Alcohol/Drug Abuse Records*
- ☐ Therapy or Counseling Notes/Summaries*
- ☐ Others _____

**In compliance with state and federal laws which require special permission to release otherwise privileged information, please release the checked records.*

I understand that if I do not specify an expiration date below, this authorization will expire six (6) months from the date on which it was signed.

This authorization shall expire on: _____

By entering my signature below and submitting this form, I acknowledge that I have been provided ample opportunity to read this document or that it has been read to me. I give this authorization freely and understand that it may be revoked by me at any time by submitting a written request.

Patient Signature * _____

Date _____