Authorization to Release or Obtain Health Information
(including paper, oral, and electric information)

Name: _____ **Request Date:** _____
Mailing Address: _____ **Date of Birth:** _____
City/State/Zip: _____ **SSN:** _____

I authorize:
Name: _____ **Of:** Cenla Professional Counseling, LLC
Mailing Address: 4207 Parliament Drive, Suite B **City/State/Zip:** Alexandria, LA 71301
Telephone: (318)787-6805 **Fax:** (318)787-6818
Relationship: ☐ Licensed Professional Counselor
☐ Licensed Clinical Social Worker

☐ To Release Information TO OR ☐ To Obtain Information FROM

Name: _____
Mailing Address: _____
City/State/Zip: _____
Telephone: _____ **Fax:** _____

The purpose of this authorization is indicated below:
☐ Further medical care ☐ Legal investigation or action ☐ Personal
☐ Changing physicians ☐ Creating health information for disclosure to a third party
☐ Other: _____

I authorize the release of the following protected health information:
☐ Entire record ☐ Medical history, examination reports ☐ Prescriptions
☐ Hospital records, including reports ☐ MR/DD records ☐ Social history
☐ Progress notes ☐ Psychological evaluations ☐ Treatment plan
☐ Educational evaluations
☐ Other: _____

In compliance with state and/or federal laws, which require special permission to release otherwise privileged information, please release the following records:
☐ Alcoholism ☐ Drug Abuse ☐ Mental Health
☐ Vocational Rehabilitation ☐ Sexually Transmitted Disease ☐ HIV
☐ Genetics ☐ Psychotherapy note
☐ Other: _____

This authorization shall expire on _____ (date or event) and is needed for the period beginning _____ and ending _____ . I understand that if I do not specify an expiration date, this authorization will expire six months from the date on which it was signed. I acknowledge that I have read this form.

_____
Signature of Individual or Personal Representative Date

_____
Signature of Witness (if signed with an "X" or mark) Date