

Authorization to Release or Obtain Health Information

|  |  |
| --- | --- |
| Name |  |
| Mailing Address | Date of Birth |
| City/State/Zip | Phone Number |
| I authorize: | |
| Name: \_\_\_\_\_Collaborative Minds LLC\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Mailing Address:\_\_\_\_\_\_\_\_10517 Kentshire Court\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| City, State, Zip Code: \_\_\_\_Baton Rouge, Louisiana 70810 | |
| Telephone Number:\_\_225-456-2884\_\_\_\_\_\_\_ | Fax Number:\_\_\_\_\_\_225-456-2892\_\_\_\_\_\_\_\_\_\_\_\_ |
| * **TO RELEASE information TO OR** | * **TO OBTAIN Information FROM** |
| Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| City, State, Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Telephone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Fax Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| The **Purpose of this Authorization** is indicated in the box (es) below. *( Place an “X” in the box (es) that apply)* | |

□ Further Medical Care □ Personal □ Legal Investigation or Actions □ Changing Physicians

□ Research related treatment □ creating health information for disclosure to a third party

□ Other: (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I authorize the release of the following protected health information.**

□ Entire Record □ Medical History, Examination, Reports □ Surgical Reports □ Treatment or Tests

□ Medication List □ Immunizations □ Hospital Records including Reports □ Lab Reports

□ X-ray Reports □ MR/DD records □ EKG/ECG Reports

□ Other: (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 □ HIV (AIDS)

□ Sexually Transmitted Diseases □ Genetics □ Psychotherapy Notes

**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 and expiration date, this authorization will expire twelve (12) months from the date on which it was signed. I acknowledge that I have read this form. I may revoke this authorization at any time by providing my written revocation to the address at the top of this form. My revocation will not apply to information already retained, used, or disclosed in response to this authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Individual or Personal Representative Authorized by Law Date

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Signature of Witness *(If signed with and “X” or mark)*  Date