Body Mind and Spirit Counseling & Wellness Center LLC
8738 Quarters Lake Rd. Bldg #5
Baton Rouge, LA 70809
225-276-6982
Email: bodymindspirit@cox.net

Authorization to Release or Obtain Health Information

(including written, verbal, and electronic information)

Client Name * _____

Client Address * (Line 1) _____

(Line 2) _____

(City/State/Zip) _____

Request Date _____(MM/DD/YYYY)

Client Date of Birth * _____(MM/DD/YYYY)

AUTHORIZATION

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

I authorize Body Mind and Spirit Counseling & Wellness Center, LLC to (check all that apply) *

☐ RELEASE Information to
☐ OBTAIN information from

Name & Relationship * _____

Mailing Address(Line 1) _____

(Line 2) _____

(City/State/Zip) _____

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

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RECORDS TO BE RELEASED

- ☐ **Changing Physician**
- ☐ **Further medical care**
- ☐ **Research-related treatment**
- ☐ **Personal use**
- ☐ **Others**

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

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

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

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

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I understand that if I do not specify an expiration date below, this authorization will expire twelve (12) months from the date on which it was signed.

This authorization shall expire on: _____ (MM/DD/YYYY)

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.

Client Signature: * _____ Date: _____