Lafayette Psychology Center
www.LafayettePsychologyCenter.com
1538 W. Pinhook Rd. • Lafayette, LA 70503 • 337.234.4912

Authorization for Release of Information

Patient Name: _____
Date of Birth: _____

I authorize _____ to disclose my mental health information to _____.
Purpose for which disclosure is to be made:
_____.

Information to be discussed:
_____Discharge Summary _____Consultation _____ Psychological Report _____Letters or Reports
_____Treatment Plan _____Social History _____Billing Information _____Psychological Test Data
_____Diagnosis _____Progress Notes

I understand that the information to be disclosed will include mental health information relating to:
_____HIV Infection _____Mental Health Treatment
_____Treatment for Alcohol/Drug Abuse _____Psychological Testing

I understand that if the person(s) or entity(s) that receive this information is not a mental health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and I am no longer protected by those regulations. Therefore, I release Lafayette Psychology Center, it's employees, Partners, Associates and /or my therapists from all liability arising from this discloser of my mental health information.

I understand that I may inspect, or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire one year from the date signed below. I understand that I may revoke this authorization by notifying Lafayette Psychology Center in writing, knowing that previously disclosed information will not be subject to my revoke request.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

_____ _____
Signature of Patient or Legal Representative Signature of Witness

_____ _____
Date Date

_____I understand by releasing this report to myself and taking a copy outside of this office, that Lafayette Psychology Center is no longer liable if any of the information if this report is released to the public. I now have full responsibility.

_____
Signature of Patient or Legal Representative

_____
Date