AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PSYCHOTHERAPY NOTES ONLY

PATIENT NAME (Last, First, Middle)	DOB

ADDRESS	SSN

CITY	STATE	ZIP

PROVIDER AUTHORIZED TO RELEASE THE PHI:	ENTITY RECEIVING THE PHI:
LA330 THE NEUROMEDICAL CENTER CLINIC 10101 PARK ROWE AVENUE SUITE 200, SECOND FLOOR BATON ROUGE, LA 70810	NAME ADDRESS CITY / STATE / ZIP ATTENTION:

This authorization will expire on the following date or event. If date or event is not indicated, authorization will expire 12 months from date signed.

Date: Event:

Purpose of this Disclosure:

PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE

Description	Start Date	End Date
PSYCHOTHERAPY NOTES		

The following information will be released when included in the above information unless you indicate otherwise:

AIDS or HIV test results
Alcohol, drug or substance abuse treatment
Psychiatric or mental care / treatment
Other (specify):

I UNDERSTAND THAT:

11. I MAY REFUSE TO SIGN THIS AUTHORIZATION AND IT IS STRICTLY VOLUNTARY.
12. MY TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS MAY NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION.
13. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING TO THE PROVIDER AUTHORIZED TO RELEASE THE PROTECTED HEALTH INFORMATION, BUT IF I DO, IT WILL NOT HAVE ANY AFFECT ON ANY ACTIONS TAKEN PRIOR TO RECEIVING THE REVOCATION.
14. IF THE REQUESTER OR RECEIVER IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS AND MAY BE DISCLOSED.
15. I HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER I SIGN IT.

Signature of Patient:	Date:
Signature of Patient's Representative (if necessary):	Date:
Personal Representative's Relationship to Patient:	