Authorization to Release or Obtain Health Information

Patient Name:	Request Date:
Address:	Date of Birth:
City/State/Zip:	Phone Number:

I Authorize:

Name: Jeremy H. Broussard, PhD, LPC (www.drjeremybroussard.com)

Mailing Address: PO Box 62731

City, State, Zip Code: Lafayette, LA 70596

Telephone Number 225-573-5140 Fax Number: 337-205-7756

☐ **RELEASE Information TO** **or** ☐ **OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Telephone Number_____ Fax Number:_____

The purpose of this authorization is indicated in the box(es) below: □ Medical Care/Consultation □ Personal □ Legal Investigation or Action □ Other: (*Specifiy*)_____	I authorization the release of the following protected health information: □ Entire Record □ Treatment Plan □ Treatment Plan □ Assessments/Tests/Evaluations □ Progress Updates

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

□ Alcoholism □ Drug Abuse □ Genetics □ HIV/AIDS □ Mental Health

□ Psychotherapy Notes □ STD's □ Vocational Rehabilitation

□ Other:_____

This authorization shall expire on _____. I understand that if I do not specify an expiration date, this authorization will expire in 5 years or as long as this client is in treatment, whichever is longer. I understand that I may revoke this authorization at any time. I authorize a copy (electronic or faxed) of this form for the disclosure of the information described above.

_____ _____

Signature of Legal Representative/Responsible Party Date