187 Burt Blvd. Suite B., Benton, LA 71006
(318) 935-5007

AUTHORIZATION FOR DISCLOSURE OF MENTAL HEALTH TREATMENT INFORMATION

Client Name: _____ DOB: _____/_____/_____

I authorize North Bossier Counseling, LLC to:

☐ OBTAIN information from ☐ DISCLOSE information to

Organization: _____ Contact: _____

Address: _____ Telephone: _____

City, State, Zip: _____ Fax: _____

Information to be used/disclosed consists of mental healthcare information, including:

- ☐ Coordination of Care
- ☐ Assessment or Evaluation
- ☐ Treatment Plan
- ☐ Notes
- ☐ Other: _____

I UNDERSTAND THAT I AM NOT REQUIRED TO SIGN THIS AUTHORIZATION.

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Courtney Miller at North Bossier Counseling. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. If North Bossier Counseling has already used or disclosed information, that cannot be undone.

I further understand that North Bossier Counseling will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____.

Unless sooner revoked, this authorization expires on the following date: _____, or as otherwise indicated:

_____.

I HAVE READ THIS AUTHORIATION & UNDERSTAND IT.

Client Signature: _____ Date:_____

Parent/Guardian/Representative Signature: _____ Date:_____

If personal rep, print name: _____

Relationship to client: Parent Legal guardian Power of Attorney/Healthcare Other: _____

Staff Signature: _____ Date: _____

☐ **PATIENT REFUSED TO SIGN THIS AUTHORIZATION.**