**Professional Counseling Alternatives**
**Avis D Lawrence, LCSW**
**18389 Petroleum Drive Suite C**
**Baton Rouge, Louisiana 70809**

# HIPAA Authorization to Disclose Protected Health Information

I hereby give permission for my personal medical information to be used and given out as described below.

Patient Name: ______________________________________________

Patient Date of Birth: ______________________________________

The following person(s) or organization(s) are permitted to provide the information:

______________________________________________________________

______________________________________________________________

The following person's or organizations are permitted to receive and use the information (name, address and telephone number):
Professional Counseling Alternatives
18389 Petroleum Drive, Suite C
Baton Rouge, La 70809
225-910-2477 (ph)
225-647-3213(fax)

The above-named are permitted to receive the information for the limited purpose of obtaining and using any and all information the releasing person(s) or organization(s) may have concerning treatment or services rendered to the undersigned for any reason, including but not limited to notes (handwritten and/or typed), charts, medical reports, face sheets, discharge summaries, history and physical, consults, , progress notes, , therapy records, diagnoses, prognoses, histories, and/or any other medical information regarding any treatment, whether inpatient or outpatient. This specifically includes documents to and from other health care providers, insurance companies, etc.

This authorization is initiated at my request and the health information will be disclosed at my request. Health information released as a result of this authorization may be re-disclosed or shared by the persons or organizations

**receiving the information and might not be protected by federal or state regulations upon such disclosure. This document further allows the provider to bill for insurance benefits reimbursement.**

**I understand that I may refuse to sign this authorization. I further understand that my refusal to sign will not affect my ability to obtain treatment unless a third party requests that treatment and/or release of information.**

**I understand that I may revoke, or withdraw, this authorization at any time by sending a written notice to the above-named person or organization authorized to release the information. This revocation will be effective for future uses and disclosures of the information described above. The revocation will not have any effect on information already used or given out.**

**This authorization expires upon final resolution of the litigation entitled:**

________________________________________________________

________________________________________________________

**I authorize the release of records only, and do not authorize oral communications by the health care provider to the authorized requesting person(s) or organization(s).**

**A photocopy of this form will serve as an original.**

________________________________ ________________________

**Signature of Patient or Representative** **Date**

________________________________

**Printed Name of Patient**

________________________________

**Relationship to Patient if Signed by Representative**

**A copy of this completed form must be given to the patient or the person signing on the patient's behalf.**