Joshua Primeaux, LCSW
103 Gisele Street
New Roads, LA 70760
(225) 323-8180

Authorization to Release Confidential Information to Family Members

A. I, _____, Date of birth: ____/____/____, Social Security #: _____, understand that the purpose of this release is to assist with my/this client's treatment by improving communication between professional service providers or agencies and the important individual(s) in my/the client's life.

B. To further this goal, I authorize Therapeutic Refuge, LLC and/or Joshua Primeaux, LCSW to release the below-specified information regarding me/the client to the individual(s) listed below, and to receive information from them in any format including by telephone. I have been informed of the risks to privacy of the use of electronic means of information transfer, and I accept these.

C. The information to be disclosed is marked by an × in the boxes below, and any items not to be released have a line ~~drawn~~ through them:

- Name of my therapist(s) ❑ Name of case manager ❑ Name(s) of treatment program(s)
- Diagnoses ❑ Prognoses ❑ Treatment plan ❑ Scheduled appointments and attendance
- Progress notes ❑ Compliance with treatment ❑ Discharge plans ❑ Treatment summary
- Psychological or other evaluations ❑ Medications ❑ Other: _____

D. This information is to be disclosed to these persons, who have the indicated relationship to me/the client:

_____ _____
Name of person Relationship

_____ _____
Name of person Relationship

_____ _____
Name of person Relationship

E. I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire ❑ 1 year from this date OR ❑ upon my discharge from treatment by this agency or by the person specified above OR ❑ under these circumstances: _____

F. Signatures:

_____ _____ ____/____/____
Signature of Client Printed name Date

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_____ _____

Signature of parent/guardian/representative if needed Printed name

_____ ____/____/____

Relationship Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____ _____ ____/____/____

Signature of witness Printed name Date

_____ ____/____/____

Relationship Date

- ❑ Copy for Client or parent/guardian
- ❑ Copy for provider/therapist/case manager
- ❑ Copy for family member