Joshua Primeaux, LCSW
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Authorization to Release Confidential Records and Information

A. Identifying information about me/the patient

Name: _____ Date of birth: ___/___/___

Current phone(s): _____ Social Security #: _____ Medical record #: _____

Name of parent/guardian (if applicable): _____ Phone #: _____

B. Because I believe it is in my/our best interest, I authorize the release of information described below:

FROM: SOURCE	**TO:** RECIPIENT
Person or organization: _____	Person or organization: _____
Address: _____ _____	Address: _____ _____
Phone: _____ Fax number: _____	Phone: _____ Fax number: _____
Secure email: _____	Secure email: _____

C. The records to be disclosed are marked by an × in the boxes below. The items *not* to be released have a line ~~drawn~~ through them. All episodes of care are to be included unless page numbers and/or dates are indicated.

- Inpatient or outpatient treatment records for physical/medical and/or psychological, psychiatric, or emotional illness
- Date(s) of inpatient admission: ___/___/___ to ___/___/___
- Date(s) of outpatient treatment: ___/___/___ to ___/___/___
- Other identifying information about the service(s) rendered: _____
- Social, family, developmental histories
- Assessments with diagnoses, prognoses, and recommendations, and all similar documents
- Academic or educational records
- Information about how the patient's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work
- Billing records
- Other records: _____

D. I authorize the transfer of these records for the following purpose(s) or uses:

- Further mental health evaluation, treatment, or care
- Treatment planning ❑ Qualification for services or benefits
- Other: _____

E. I authorize the Source named in section B above to share by telephone and/or face to face with the Recipient professional in section B any information that can assist with my/the patient's receiving treatment.

F. I understand the consequences if I refuse to allow this release. My consent is fully voluntary.

G. I understand that the Source of the information has no control of it after it has left the Source's premises.

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H. I understand that I may revoke this ROI authorization, but that doing this will not bring back the information that was released before the date of the revocation. I can do this at any time by writing to the Source named in section B. If I do not void or cancel this ROI authorization, it will automatically expire 90 days from the date I signed it.

I. I have had the provisions of this form explained to me and believe that I fully understand this ROI.

J. Signatures:

_____ _____ ____/____/____

Signature of patient | Printed name | Date

_____ _____

Signature of parent/guardian/representative if needed | Printed name

_____ ____/____/____

Relationship | Date

❑ Copy for patient or parent/guardian ❑ Copy for Source of records ❑ Copy for Recipient of records