RNLF Counseling Services

7569 E. Industrial Dr
Baton Rouge, LA 70805
PHONE (225) 810-3967 **FAX (225) 810-3968**

Authorization to Release or Obtain Health Information
(Including written, verbal, and electronic information)

Name of Client:	Request Date:
Mailing Address:	Date of Birth:
	Social Security #:

I authorize RNLF Counseling Services to:

RELEASE Information TO and/or OBTAIN Information FROM

Name & Relationship:			
Mailing Address:			
City, State, Zip Code:			
Phone Number:		Fax Number:	

The Purpose of this Authorization is indicated in the box(es) below:

Mental health evaluation and/or treatment	Coordinating interdisciplinary treatment
Legal investigation or action	Changing physician Research-related treatment
Creating health information for disclosure to a third party	Further medical care Personal use
Other purpose (specify):	

I authorize the release of the following Protected Health Information (PHI).

Entire Record Medical History Prescription Immunizations Hospital Records Radiology Reports

Surgical Reports Laboratory Reports Genetic Testing Results* Mental Health Records* Voc-Rehab Records*

HIV/AIDS Information* Sexually Transmitted Disease* Alcohol/Drug Abuse Records* Therapy or Counseling Notes/Summaries*

Other PHI (specify):

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

This authorization shall expire on _____(date.) I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I give this authorization freely and understand that it may be revoked by me at any time by submitting a written request.

_____ _____
Signature of Individual Date

_____ _____
Parent or Personal Representative authorized by law Date

_____ _____
Signature of Witness Date