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**CONSENT TO RELEASE INFORMATION**

All information that has been gathered on an individual is personal and private, and this information cannot be released without authorized written permission except as permitted by law.

***I understand that the information in the record of:***

Name*: Click or tap here to enter text.* DOB*:* Click or tap to enter a date.

Address (Street Name, City, State and Zip Code): Click or tap here to enter text.

***Is personal and private; however, I give permission for***

Forensic Therapy Wellness

144 Valhi Lagoon Crossing

Houma, LA 70360

P: (985) 266-3523

F: (985) 238-3696

***To Release Information To and Receive Information From:***

Person/Agency Name: Click or tap here to enter text. Phone #: Click or tap here to enter text.

Address (Street Name, City, State and Zip Code): Click or tap here to enter text.

**I authorize the release of the following protected healthcare information:**

[ ] Entire Record [ ] Assessment [ ]  Diagnosis [ ] Treatment Plans [ ]  Progress Notes [ ] Hospital Records [ ]  Labs [ ] Treatment or Tests [ ]  Attendance [ ]  Medical History [ ] Screening/Eval [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **For the Purpose of:**

[ ] Changing Treatment Providers [ ] Legal Investigation or Action [ ] Personal

[ ] Providing Information about my Treatment [ ] Collaborating/Participating in my Treatment

[ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R pts 160& 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically ***one year after it has been signed:*** ***(date)***Click or tap to enter a date.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

 Click or tap here to enter text.

Signature of Client

Click or tap to enter a date.

Date