

Release of Information

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Please execute the following form for authorization to release or obtain health information.

Date _____
Client Name _____ Date of birth _____ Age _____
Address _____ Phone No. _____
City _____ State _____ Zip _____

I hereby authorize:

Walter Camos, MS, LPC, NBCCH
102 Independence Boulevard, Lafayette, Louisiana 70506
Phone 337.484.1333 Fax 337.806.9241

To release information to or to obtain information from:

Name _____ Relationship _____
Mailing Address _____ Phone No. _____
City _____ State _____ Zip _____ Fax No. _____

Concerning the items listed and for the purposes and reasons below:

- | | | | |
|---|--------------------------------------|---|---|
| <input type="checkbox"/> Continued Care | <input type="checkbox"/> Referral | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Treatment |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Verbal Communication | <input type="checkbox"/> Discharge Info |
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Evaluations | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

I understand that I do not have to sign this form and that my participation herein is completely voluntary. I also understand that I can cancel this authorization at any time by notifying Walter Camos, MS, LPC but only to the extent that any information already changed hands cannot be taken back. Information that is disclosed by this authorization may be re-disclosed by the recipient and therefore can no longer be protected by Walter Camos, MS, LPC. I hereby authorize the above release of information as shown for the reasons listed by my signature below, either by hand or electronically.

Client's Signature _____ Date _____

Parent / Guardian Signature _____ Date _____