Release of Information

Walter Camos, MS, LPC
Licensed Professional Counselor
102 Independence Boulevard, Lafayette, Louisiana 70506
337.484.1333 www.camostherapy.com Fax 337.806.9241

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

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:

( ) Continued Care	( ) Referral	( ) Mental Health	( ) Treatment
( ) Progress Notes	( ) Diagnosis	( ) Verbal Communication	( ) Discharge Info
( ) Entire Record	( ) Evaluations	( ) _____	( ) _____

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 _____