



AUTHORIZATION TO OBTAIN INFORMATION

Client Name: _____ DOB: _____ SS# _____ grant
permission for release of information **from** the agency and/or individual identified below **to Tammy Lewis Wilborn, PhD, LPC-S, LPC/MHSP, NCC/ Wilborn Clinical Services, P.O. Box 872873 New Orleans, LA 70187** which may include any applicable verbal and/or written documentation relating to the client (s) named above:

Name of Agency or Individual

Address

Concerning my right to confidentiality, I hereby authorize the release of the following specific information under the protection of federal law:

(CHECK ALL ITEMS THAT APPLY)

- 1. Medical History
- 2. Psychiatric evaluation reports
- 3. Psychological assessment reports
- 4. Biopsychosocial history
- 5. Progress summary
- 6. Treatment summary
- 7. Discharge summary
- Other (specify) _____

I UNDERSTAND THAT THIS INFORMATION WILL BE USED FOR THE FOLLOWING SPECIFIC PURPOSES:

(CHECK ALL ITEMS THAT APPLY)

- 1. To develop a diagnosis and treatment plan
- 2. To facilitate additional treatment recommendations
- 3. Other: _____

The requested information will be used for my continued treatment. However, I understand that I may revoke this consent to release of information at any time. However, I also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization to release information shall expire **one year** from this written consent. At that time, no express revocation shall be needed to terminate my consent. This consent for release of information is given freely, voluntarily, and without coercion. I understand that a copy of this release of information shall be accepted and valid. **NOTE TO AGENCY OR INDIVIDUAL RECEIVING THIS INFORMATION: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS LEGALLY PROTECTED. STATUTES/REGULATIONS PROHIBIT YOU FROM MAKING FURTHER DISCLOSURE WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHO IT PERTAINS OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.**

Signature of Client (or guardian if applicable)

Date

Signature of Clinician

Date