# AUTHORIZATION TO RELEASE INFORMATION

Client Name: _____________________________________________DOB:_____________SS#_______________grant permission for release of information **from** Tammy Lewis Wilborn, PhD, LPC-S, LPC/MHSP, NCC/ Wilborn Clinical Services, P.O. Box 872873 New Orleans, LA 70187 **to** the agency and/or individual identified below 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. STATUES/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 REULATIONS. 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