AUTHORIZATION TO RELEASE/OBTAIN HEALTH INFORMATION

I, _____, SSN _____ DOB _____,
(Patient Name)

residing at _____ hereby authorize:
(Patient Address)

_____ To release to: Om Counseling, LLC
Name of Disclosing Entity Name of Receiving Entity (Recipient)

Recipient's Address:

_____
Address 3909 Ambassador Caffery Pkwy, Ste I

_____ Lafayette, LA 70503
City, State, Zip Code City, State, Zip Code

The following Health Information under this authorization:

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Psychiatric Evaluation
- ☐ Physician's Progress Notes
- ☐ Physician Orders
- ☐ Laboratory and X-ray reports
- ☐ Weekly Progress Reports
- ☐ Treatment Plan
  - ☐ Verbal reports
- ☐ Psychosocial Assessment

☐ Complete Medical Record (Must justify reason for complete record) _____

☐ Other (specify, may be verbal) _____

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- ☐ Alcohol/Drug Abuse Treatment/Referral
- ☐ Sexually Transmitted Diseases
- ☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)
- ☐ HIV/AIDS-related Results / Treatment
- ☐ Mental Health (Other than Psychotherapy Notes)

Dates of service that are covered by this authorization: _____

This authorization will **expire on (date)** or after (**event)** _____

Purpose of Disclosure (check one):

- ☐ Coordination of patient care
- ☐ At the request of patient
- ☐ To transfer patient to another facility
- ☐ Other: _____

You have the right to refuse to sign this authorization. We cannot condition treatment or payment upon your signing this authorization. Your rights to protect and inspect your health information are explained in our Notice of Privacy Practices. A photocopy of this authorization may serve as an original. Your health information may not be protected under the Privacy Rule after it has been disclosed to the recipient of this Authorization. You can revoke this Authorization to release health information at any time, except to the extent that we have already released the health information before obtaining the revocation. You can revoke this authorization by sending a written request to: Divya Kasturi, LPC at the above-mentioned address.

_____ Date: _____
Patient Signature *(If unable to sign, document reason for lack of capacity to provide signature)*

_____ _____ Date: _____
Personal Representative Signature (if applicable) Relationship

_____
Witness

PERSONAL REPRESENTATIVE INFORMATION

If it is necessary for a personal representative to sign and date this authorization due to lack of capacity of the patient, including minority, interdiction or any other legal reason, indicate below, by checking the applicable block. Document authority in medical record or retain copy of documents in medical record.

- ☐ The judicially appointed tutor or curator of the patient, if one has been appointed
- ☐ An agent acting pursuant to a valid mandate, specifically authorizing the agent to make health care decisions (Power of attorney)
- ☐ The patient's spouse not judicially divorced
- ☐ Any parent, whether adult or minor, for his minor child, An adult child of the patient/client
- ☐ The patient's sibling
- ☐ The patient's other ascendants or descendants
- ☐ Any person temporarily standing *in loco parentis,* whether formally serving or not, for the minor under his care any guardian for his ward (Person acting in place of the parents)
- ☐ Other: (Specify)_____