Om Counseling

Authorization for Release of Information

I (we) authorize _____(Phone #(____) _____-_____), (Fax# (_____) _____-_____) to release and exchange information with:

Divya Kasturi, LPC-S, NCC, 1921 Kasliste Saloom Rd., Suite 202 A, Lafayette, La 70508

Phone: (337) 385-3991 Fax: (888) 466-0744.

From the clinical records of _____(patient)

DOB: _____

For the purpose of:

_____ Coordination of care. _____ Treatment planning

Information to be released may include:

___Diagnosis ____ Clinical impressions _____ Summary of Treatment

___ Medication compliance _____ Progress notes ____ Other

Specify the information to be obtained: _____

_____.

Patient Authorization

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted disease, drug or alcohol abuse, mental illness, psychiatric treatment or psychotherapy treatment. I give my specific authorization for these records to be released. I understand that this information is released for professional purposes and may not be re-disclosed, without the consent of the person who has signed this form.

_____ _____

(Signature of the patient/ guardian) (Date)

_____ _____

(Witness) (Date)

1921 Kasliste Saloom Rd., Suite 202 A, Lafayette, LA 70508
www.omcounseling.net
Ph: (337) 385-3991 Fax: (800) 466-0744