Commit to Change

with Dr. Renee B Bonin & Associates
200 Beaullieu Dr. Bldg 9B-1
Lafayette, LA 70508
Phone: 337-504-3483
Fax: 337-504-3573

Authorization to Release Information

FOR THE RELEASE OF PROTECTED MENTAL HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____

Address: _____

☐ I authorize my provider to ☐ RELEASE ☐RECEIVE psychological/psychiatric mental health information to/from the SECOND PARTY as directed below:

SECOND PARTY

Name: _____

Address: _____

Fax #: _____ Phone #: _____

TYPE OF INFORMATION TO BE DISCLOSED

☐I authorize disclosure of all health information, including information relating to medical, pharmacy, mental health, substance abuse, and psychotherapy.

☐I authorize only the disclosure of the following information:

_____

PURPOSE OF DISCLOSURE

☐My health information is being disclosed at my request or at the request of my personal representative; or

☐My health information is being disclosed for the following purpose:

_____

Note any exclusions or limitations here: _____

_____

I understand that treatment, payment, enrollment in health plan, or eligibility for benefits is not dependent on my signing this authorization. By signing below, I acknowledge that I have read and understand this document and that I have voluntarily given my provider authorization to disclose my records. I understand that I may revoke this authorization at any time by providing a written notice to my provider, however the revocation will not have an effect on any actions taken prior to the date my revocation is received. I understand that my information may be redisclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of the agreement.

Signature: _____ Date: _____

☐Authorization is given to this patient's behalf due to being a minor or unable to sign.

Legal Guardian/Personal Representative Signature: _____ Date: _____