Authorization to Release Information

Patient's Name: _____ Date of Birth: _____

Address: _____

By signing this form, I give permission to Dr. Renee B Bonin, PhD, MP, Dr. David Landry, Ph.D., Tiffany Capps, LPC, Mary Huval, LPC, Dr. Mike McDermott, PhD, or Aimee Dupuy, PLPC (200 Beaullieu Dr Bldg 9B-1, Lafayette, LA) and

_____

(Primary Physician, therapists, judges, family members, etc)

____ I give my permission for disclosure of the following information: (Please initial)

_____ Mental Health Evaluations
_____ Progress Notes
_____ Other: _____

I understand that I can revoke this authorization at any time and that the revocation must be presented in writing.

_____ _____

Patient Signature (or parent if patient is a minor) Date

_____

Printed Name