Conquest Counseling

The purpose of this form is to authorize ***Conquest Counseling*** *to share protected health information with the identified third party for the purposes of treatment, payment, and health care operations. If you refuse to authorize any such disclosure, complete the box labeled "Restriction on Disclosure". Otherwise, please complete the form as indicated.*

CLIENT

Last Name _____ First Name _____ Date of Birth _____

THIRD PARTY

Organization/Individual Name

Address

Telephone Fax

I authorize **Conquest Counseling** to (check all that apply):

_____ Release to _____ Obtain from _____ Discuss with

the third party identified above the specified protected health information listed below for the purpose of treatment, payment, and health care operations.

CHECK EACH APPLICABLE ITEM

_____ Admission Evaluation Report
_____ Diagnosis Only
_____ Treatment Plan(s)
_____ Psychiatric Consultation Report
_____ Psychological Report
_____ Progress Review(s)
_____ Alcohol/Drug Treatment Information
_____ Hospitalization Screening
_____ Medical Reports
_____ Legal Reports
_____ Educational Reports
_____ HIV/AIDS Information
_____ Other: _____
_____ Progress Notes:
from _____ to _____

This authorization shall remain in effect until _____ (date) at which time this authorization expires, but no later than one year listed from the date listed above. If this item is left blank, the authorization shall remain in effect for one year from the date listed below.

I understand that enrollment, eligibility, payment, or treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records. I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by providing written notice of revocation to Shamyra Howard, LCSW at the following address: Conquest Counseling 4845 Jamestown Avenue, Baton Rouge, Louisiana 70808

Signature of Client/Client Representative _____ Date _____

Printed Name of Client/Client Representative and Relationship to Client

Witness Signature with Credentials/Title _____ Date _____

RESTRICTION ON DISCLOSURE: The sharing of protected health information between any third party who has or is treating the Client and for the purposes of treatment, payment, or health care operations is not authorized.

Signature of Client/Client Representative

Printed Name of Client/Client Representative and relationship