Client #: _____
Office Use Only

Jacosta Parker, LCSW, MSW
parkercounselingservices@gmail.com
(504) 905-8100

Authorization for Use and Disclosure of Protected Health Information

Client Name: _____ Birthdate: _____

Social Security #: _____ Phone #: _____

Address: _____

I hereby authorize Parker Counseling Services, LLC. to ☐**release** ☐**obtain or** ☐**exchange:** protected health information of the above person to:

Name: _____ Relationship: _____ Phone #: _____

Address: _____

Information to be disclosed:
☐ Psychiatric Evaluation
☐ Frequency and Service Type
☐ Current Diagnosis and Medication
☐ Treatment Plan
☐ Discharge Summary
☐ Other: _____

Purpose of Disclosure:
☐Further medical care
☐ Coordinating services/ treatment
☐ Changing provider
☐ Personal Use
☐ Other: _____
☐ Other: _____

- I understand I have the right to refuse to sign this form and I do not have to sign this form to receive mental health services.
- I may revoke my consent at any time in writing by delivering my revocation to Parker Counseling Services, LLC. The revocation will not apply to information that has already been released.
- This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event: _____

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____
Client Signature Date

_____ _____
Parent/ Guardian Signature (If Minor) Date

Revised: 3/31/2020