AUTHORIZATION
TO RELEASE INFORMATION

BALANCE & BLOOM
THERAPY

I, _____, whose Date of Birth is _____, authorize Balance and Bloom Therapy, LLC, at 104 N. Airline Hwy, Ste C, Gonzales, LA 70737, to disclose to: _____.
Please provide relationship & contact information:
_____
_____
_____
_____

Description of Information to be Disclosed (Initial each item to be disclosed)
_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Presence/Participation in Treatment
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Other_____
_____Other_____

Limitations of Information to be Disclosed
_____

Purpose
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Balance and Bloom Therapy, at 104 N. Airline Hwy, Ste 208, Gonzales, LA 70737. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this authorization expires one year from the date signed.

Conditions
I further understand that Balance and Bloom Therapy will not condition my treatment on whether I give authorization for the requested disclosure.

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure
I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections. I will be given a copy of this authorization for my records.

_____Signature of Client
_____Date

_____Signature of Parent, Guardian or Personal Representative
_____Date
If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).
_____

_____Check here if patient/client refuses to sign authorization

_____ Signature of Staff
_____ Date