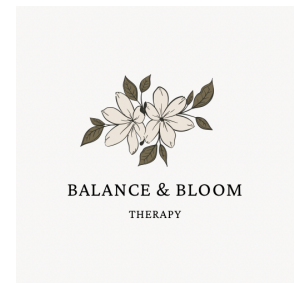


AUTHORIZATION TO RELEASE INFORMATION



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