Crescent City Psychiatric

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Name: _____ DOB: _____ SSN: _____

Mailing address: _____

Phone: _____ Date of Request: _____

I, _____ authorize:

Crescent City Psychiatric, 3045 Ridgelake Drive, Suite 102
Metairie, LA 70002
Phone: 985-249-1322, Fax: 504-301-2723

☐ **To Release information to:** ☐ **To Obtain information from:**

_____
Company/Entitiy

_____
Address

_____
City State Zip

_____
Phone Fax

The purpose of this authorization is indicated in the box(es)below. *Place an "X" in the boxes that apply.*
☐ Further Medical Care ☐ Personal ☐ Legal Investigation or Action ☐ Changing Providers
☐ Research Related Treatment ☐ Disclosure to 3rd party ☐ Other _____

I authorize the release of the following protected health information. *Place an "X" in the boxes that apply.*
☐ Entire Record ☐ Medical History, Treatment Summary and Progress
☐ Attendance ☐ Diagnosis ☐ Prescription History
☐ Date of Service _____ ☐ Other _____

In Compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records. *Please initial the areas that apply.*
___ Mental Health ___ Psychotherapy Notes ___ Alcoholism ___ Drug Abuse ___ HIV/AIDs
___ Sexually Transmitted Diseases ___ Vocational Rehabilitation ___ ___ Other: _____

I fully understand this authorization to release information and request to release or obtain records and information from my records at the nature of the records, their contents, the consequences and implications of its release, and my request is wholly voluntary on my part. I hereby release the source of these records from any liability arising from their release. I authorize the parties above to talk by telephone about my referral, diagnosis, treatment, and similar topics relevant to the above listed purpose for this release of records. I understand the provision of services is not contingent upon this releasing of information.

This "consent to release information" form is valid for one year, or as allowed by state law. I understand that I may revoke this consent at any time in writing except to the extent that action based on this consent has been taken.

_____ _____
Print Name Date Witness Signature Date

_____
Signature