LOTUS COUNSELING CENTER, LLC

Amber Trepagnier, LPC, NCC

CLIENT INFORMATION RELEASE/OBTAIN AUTHORIZATION

I, ____(Date of Birth)____________________________

Request and authorize, ____
Name of Person/Organization

____
Street Address

____
City/State/Zip Code

____
Phone/Fax

To: ❑ release or ❑ obtain or ❑ exchange information concerning medical records from

____
Name of Person/Organization

____
Street Address

____
City/State/ Zip Code

____
Phone/Fax

These records concern the time between ____________________________and _________________________

Specific Extent of Information:

❑ Intake and discharge summaries ❑ Medical history and evaluation(s)
❑ Diagnosis and treatment plan ❑ Treatment progress
❑ Verbal consultation ❑ Billing and payment
❑ Other: ____

This consent shall expire one year from this date. This information may be released by verbal communication, electronically, by telephone, by fax, or by mail.
To the Party receiving this Information: This information has been disclosed to you from the records whose confidentiality is protected by law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.
For patient records applicable Under Federal Law 42 CFR Part 2 and all other patient.

____ ____________________________
Signature of Client Date

____
Signature of parent/guardian (if the above named person is either under age 16 or has legally appointed guardian)