Xavier University of Louisiana
Counseling Services

1 Drexel Drive – Box D
New Orleans, LA 70125
Office: (504) 520-7315
Fax: (504) 520-7943

Authorization for Release of Confidential Health Information

Client Information:

Name: _____ D.O. B. _____/_____/_____

ID# or SSN: _____ Phone #: _____

I _____ authorize _____
Client Name **Name of Hospital/ Physician / Facility/ Counselor/Psychologist**

to release information specified below from my private health records to **Xavier University of Louisiana Counseling Services, 1 Drexel Drive, Box D, New Orleans, LA. 70125 or to release to outside facility/internal department _____ (please circle)**

Purpose for Release: ○Continued Care ○ Insurance ○ Legal ○ Other _____

Please place (✓) check mark next to information to be released:
□ Discharge Summary □ Discharge Instructions/After Visit Summary □ History & Physical □ Laboratory
□ Consultation Reports □ Progress Notes □ ER Record □ Entire Record
□ Other_____

Method of Delivery: □ **US Mail** - 1 Drexel Drive, Box D, New Orleans, LA. 70125 □ **Fax –** (504)520-7962
□ **Phone** _____ □ **Email** _____

The client's express authorization is required to release certain types of records, including alcohol and/or drug abuse treatment and information, HIV testing and treatment, psychiatric treatment. To authorize release of this information, please read and sign the following:

I_____ authorize the release of **psychiatric** information.
Client Name

I_____ authorize the release of **alcohol and/or drug abuse**
Client Name treatment and information.

In authorizing the release of the confidential information identified above, I hereby waive all restrictions or privileges imposed by law and release Xavier University of Louisiana and its affiliates and their staff from any restriction or privilege imposed by law in connection with the disclosure or release of any professional record, observation or communication. I do understand that the information that is being released may be subject to re-disclosure by the recipient and may no longer be protected. I understand that my treatment, may not be conditioned on signing this authorization.

This authorization may be revoked in writing at any time, except to the extent that Xavier University of Louisiana and its affiliates have already acted in reliance on it.

Letters to revoke this authorization should be addressed to Xavier University of LA, Counseling Services, Counseling Services, 1 Drexel Drive, Box D, New Orleans, LA 70125

If not previously revoked in writing, this authorization will terminate or expire upon (state the specific date, event, or condition): _____

This authorization is effective on the date signed below and continues until I revoke this authorization in writing or one year from the date signed**.**

_____ _____ ____/_____/____
Signature of Client or Authorized Representative **Relationship to Client** **Date Signed**

_____ _____ ____/_____/____
Witness Name **Witness Signature** **Date Signed**