Authorized Consent to Release Health Information

Your Name(s):_____
Mailing Address:_____ Date(s) of Birth:_____
City/State/Zip:_____
Telephone #:_____ Email address:_____

I authorize Mark Morris, LCSW at 7815 Maple St. New Orleans, LA 70118, 504-388-7463,

To Release Information TO and Exchange Information WITH:

Third Party: _____
Mailing Address: _____
City, State, Zip_____
Relationship to Client: _____ Telephone Number:_____

I authorize Mark Morris, LCSW and the above-named party to provide a copy, summary, or narrative of my medical records in both verbal and written form. The reasons or purposes for this release of information are to enhance continuity of care, evaluation and assessment, academic planning, and (if appropriate) _ _____. At this time I am requesting a complete record, including oral communications, HIV and AIDS, Sickle Cell Anemia, and Substance Abuse History, unless I limit release as follows: _ _____. This authorization shall expire one year after termination of treatment, or on _ _____.

I certify that this request has been made freely, voluntarily, and without coercion and that the information given above is accurate and complete to the best of my knowledge. Re-disclosure of my medical records by those receiving the above-authorized information may be accomplished without my further written authorization and may no longer be protected. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the provider.

I understand that if this information is to be used for more than clinical treatment (such as legal use), you may charge a fee for preparing and furnishing this information. The fee is waived if the records are to be used for supporting an application for disability or other benefits or assistance under Aid to Families with Dependent Children, Medicaid, Medicare, Supplemental Security Income, and Federal Old-Age and Survivors Insurance. If relevant, I have attached a statement that confirms that such an application or appeal has been filed or is pending.

(To be signed by patient(s) or person legally authorized to consent on patient's behalf.)

Signed:_____ Date signed: _____

Signed:_____ Date signed: _____

Ver. September 19, 2014