Granberry Counseling Centers

A ministry of the Louisiana Baptist Children's Home

Granberry Counseling Centers
7200 DeSiard St. Monroe, LA 71203
(318)345-8200 or (877)345-7411
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Request/Authorization to Release Confidential Records and Information

I, _____, born on _____,
(client/parent/legal guardian)
hereby authorize: (Person or facility): _____ Phone:_____

Address: _____
(Street) (City) (State) (Zip)
to release information to: (Person or facility) _____

Address: _____
(Street) (City) (State) (Zip)
about _____, born on _____,
(Client)
for the following purpose(s):

- ☐ Further mental health evaluation, treatment or care
- ☐ Rehabilitation program development or services
- ☐ Treatment planning
- ☐ Other _____

These records concern the time between _____ and _____.

The information to be disclosed is marked by an "x" in the boxes below, and the items not to be released have a line drawn through them.

- ☐ Intake and discharge summaries
- ☐ Developmental and/or social history
- ☐ Progress notes, and treatment or closing summary
- ☐ Medical history and evaluation(s)
- ☐ Educational records
- ☐ Mental health evaluation(s)
- ☐ Telephone consultation(s)
- ☐ Other _____

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within one year, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed.

_____	_____	_____
Signature of client	Printed name	Date
_____	_____	_____
Signature of parent/guardian/representative	Printed name	Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____	_____	_____
Signature of witness	Printed name	Date

I, a mental health professional, have discussed the issues above with the patient and/or his or her parent or guardian. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____	_____	_____
Signature of professional	Printed name	Date