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CONSENT AND AUTHORIZATION TO RELEASE PSYCHOLOGICAL, MEDICAL, SOCIAL AND EDUCATIONAL RECORDS

Pursuant to the Federal HIPAA Guidelines, concerning my right to confidentiality,

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FULL NAME **Today's Date**

authorize CINDY ASHKINS, PHD, LCSW. Contact #: 504.606.6011
Email address: Coupleslifecoach@gmail.com
to release my psychological, medical, social and /or educational records or other related information to and from:
NAME:

Contact telephone and/or email address:

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For the specific purposes of case coordination and treatment plan. This medical, educational and/or psychological information may be used by the person I authorize to receive this information for medical/psychological treatment or consultation and is in effect for a period of ninety (90) days. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient; it may no longer be protected by federal HIPAA law (Public Law 104-191) or state law.

X____

SIGNATURE DATE

X

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SIGNATURE DATE