Christine Belaire, Ph.D., LPC, LMFT, NCC
5536 Superior Dr., Suite B
Baton Rouge, LA 70816

(225) 291-1335
fax (225) 291-1336
www.BelaireCounseling.com
DrBelaire@BelaireCounseling.com

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

Pursuant to Federal Guidelines concerning my right to confidentiality, I

Name: ____ **DOB**: _______________

Authorize: **Dr. Christine Belaire**
Belaire Counseling Services, LLC
5536 Superior Drive Suite B
Baton Rouge, LA 70816

To release/exchange/receive/discuss information about:

Name: ____ **DOB**: _______________

Concerning/related to (check all that apply):

- ☐ Psychological records
- ☐ Psychotherapy notes
- ☐ Medical records
- ☐ Legal records
- ☐ Social records
- ☐ Pharmacy records
- ☐ Phone records
- ☐ Financial records
- ☐ Payment
- ☐ Comprehensive Childcare/School File
- ☐ Other:

With the following person(s)/organization (name, address, phone number):

____

____

____

____

I understand that I may revoke this consent to the release of information in writing at any time and that this consent will expire no later than sixty (60) days from the date of my last counseling appointment. I further understand that any release which has been made prior to my written revocation and which was made in reliance upon this authorization shall not constitute a breach of my right of confidentiality.

____

(Signature) (Date)