Albarado Psychiatry at Bloom
203 Building 2 Energy Parkway
Lafayette, LA - 70508

Release of Information

Client/ Patient name: *

Patient's DOB:

Dr. Albarado

Dr. Ashley Albarado is located at 203 Energy Parkway Building 2, Lafayette, LA 70508. Her office number is 337-205-9725 and fax number is 337-234-7111.

Please select the information to be shared:

- ☐ Initial Psychiatric Evaluation only
- ☐ Billing documents
- ☐ Contacts and demographic information
- ☐ Psychiatric appointment notes
- ☐ Portal messages and communication notes
- ☐ Stored documents (Intake and consent forms, external records)
- ☐ Other
- ☐ Entire record including all psychiatric or substance use history

Release to

Enter the name of the person or organization who will be communicating with or providing information to/from Dr. Albarado, and any contact information such as phone number, address, or fax. (For example, if you would like Dr. Albarado to communicate with your primary care doctor, enter that doctor's name and contact info here.) *

If you are requesting we send a copy of the records, please indicate the preferred method. You MUST provide the address, fax number, email address, etc above.

- ☐ paper copy to be mailed
- ☐ fax
- ☐ email
- ☐ paper copy to be picked up from the office

Records for the purpose of communicating with another medical provider are provided without charge. Records for legal purposes, insurance, and excessive requests may be charged. You will be contacted with the amount, and it must be paid before records are prepared. Please indicate your understanding: *

☐ Yes ☐ No

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please submit a copy of this authorization to receive this protected health information.

By adding your signature, you are eSigning this form.

PATIENT SIGNATURE *

If you are signing for the patient, please identify your relationship to patient: Parent of a minor patient Legal Guardian of patient Other