Purpose Counseling
&
Mental Health Services, LLC
"Where The Healing Begins"

**CONSENT AND AUTHORIZATION TO RELEASE INFORMATION AND RECORDS FOR CUSTODY EVALUATION**

Pursuant to Federal Guidelines concerning my right to confidentiality,

I Name: ________________________________________________ DOB: ________________

Authorize: Rochelle Gipson Brady, MSW, LCSW

Purpose Counseling and Mental Health Services, LLC

Prairieville, LA 70769

To release/exchange/receive/discuss information about the following person(s):

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 six (6) months from the end of the custody evaluation. 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)