Client Information

Name: _____ Date:_____
Date of Birth: _____
Parent's Names, if minor _____
Address:
_____
_____
Phone (hm): _____ Cell: _____
Work: _____
Information of person responsible for bill other than client:
Name: _____
Address: _____
Phone: (hm) _____ Cell: _____
Work: _____
Referred by: _____

Authorization for Release of Information

Please provide the following if you are currently seeing a physician or counselor. This will allow the exchange of information in order to work together for you.

I authorize:

Hilary Shaw, LPC RD
717 S. Foster Drive Suite 140
Baton Rouge, LA 70806
(225) 387-3691

to exchange records and discuss my case with:

_____
_____
_____

regarding medical/counseling information related to the nutritional, mental, and medical health of the above registered client.

_____ _____
Signature of Client or Responsible Party Date